# Delaware Medical Journal

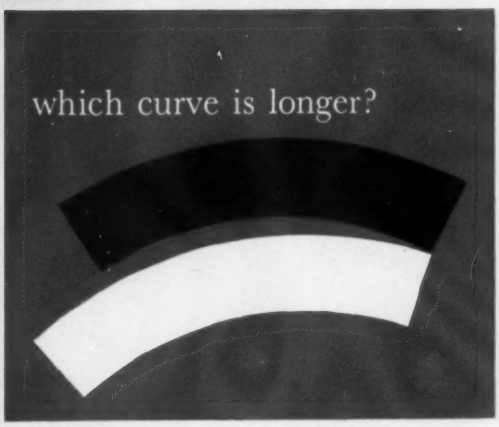
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Official Publication of the Medical Society of Delaware

1789 INCORPORATED


**NOVEMBER, 1961 . . .**

**MENTAL HEALTH ISSUE**


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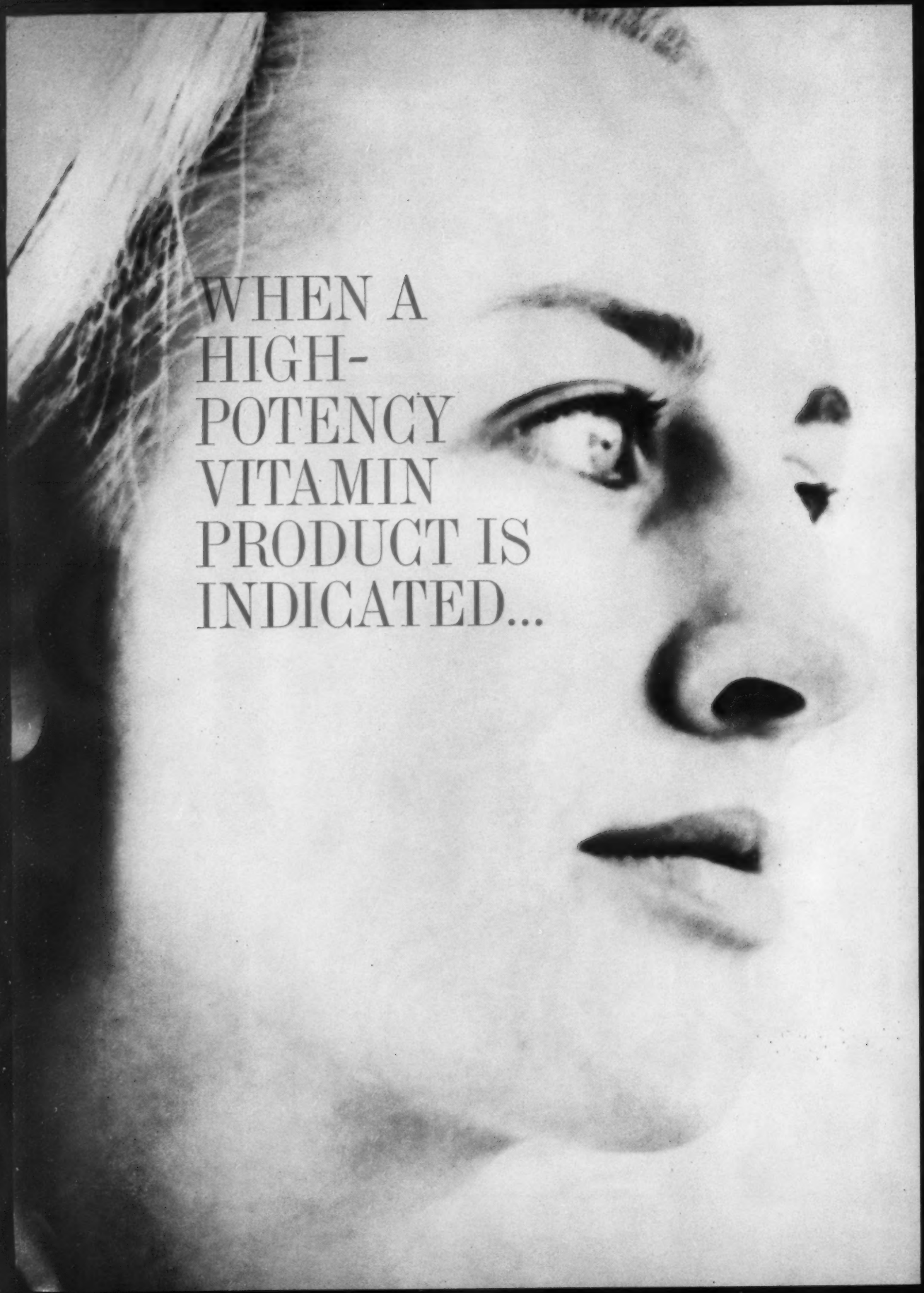
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1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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# Delaware Medical Journal

Official Publication of the Medical Society of Delaware

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1925 LOVERING AVENUE, WILMINGTON 6, DELAWARE

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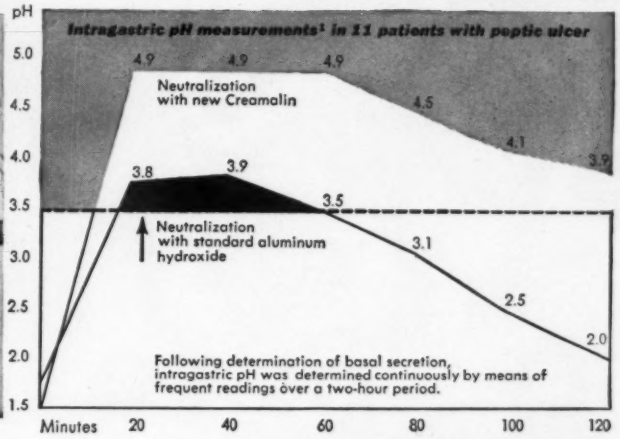
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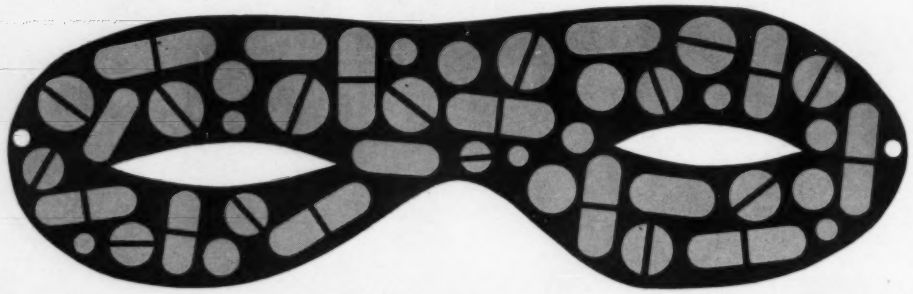
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Rhode Island Medical Journal,
January, 1961

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Director of Revision of the U.S.P.

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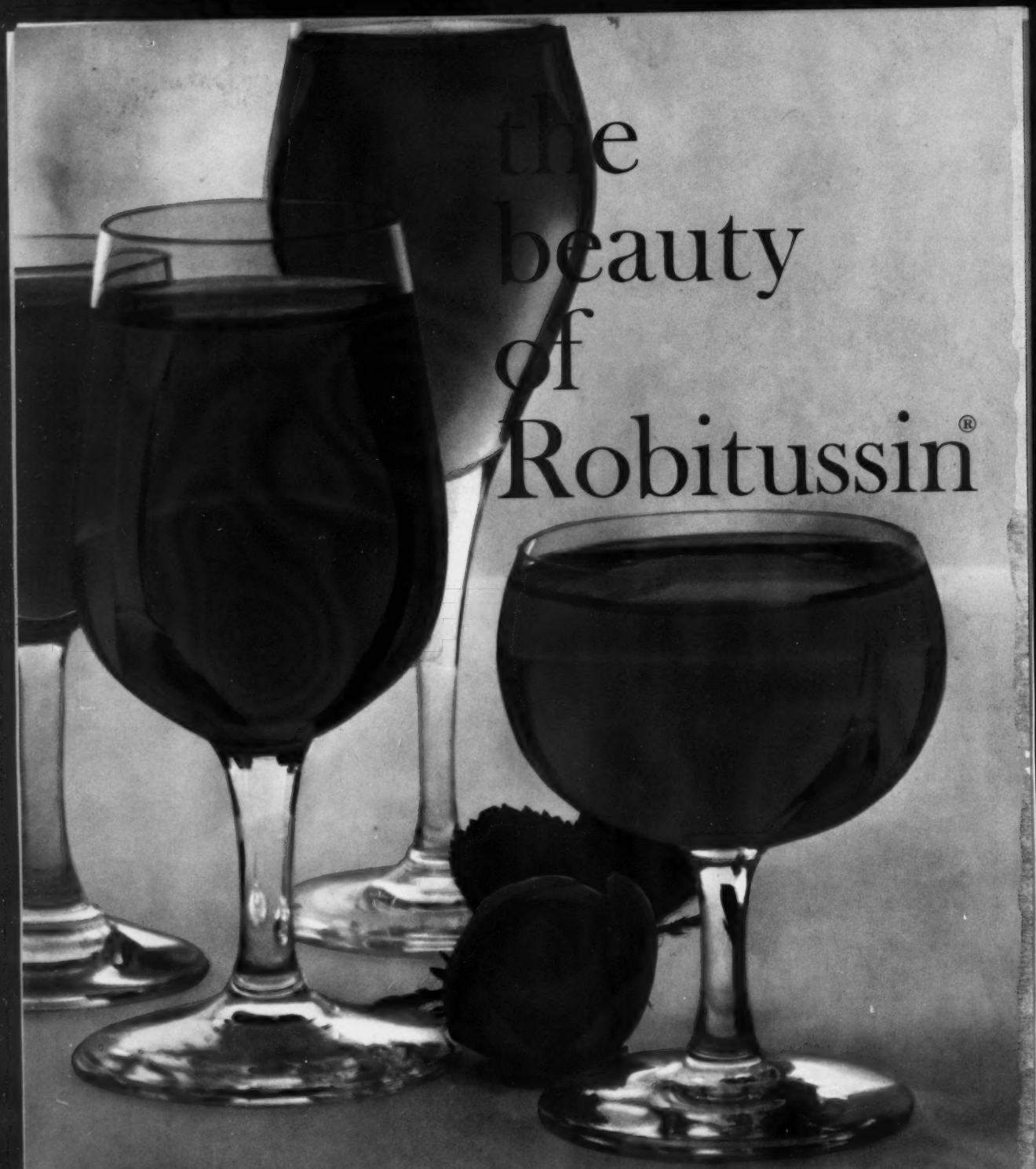
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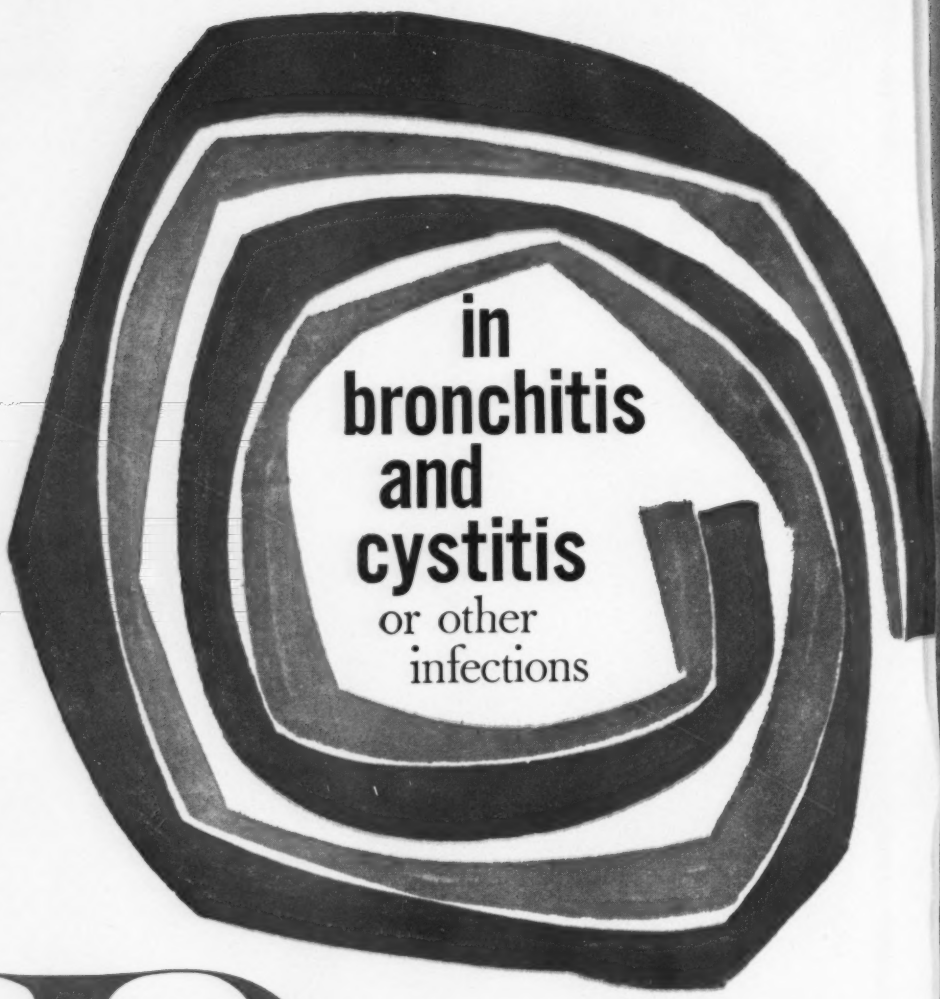
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SULZBERGER, M. B. & WITTEN, V. H.: The Management of Acne Today. Med. Clinics of No. America, 43:3, May 1959.

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| | 100% |

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*cough sedative | antihistamine*
*nasal decongestant | expectorant*

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| Pyrilamine Maleate | | 12.5 mg. |
| Phenylephrine Hydrochloride | | 10 mg. |
| Ammonium Chloride | | 60 mg. |
| Sodium Citrate | | 85 mg. |

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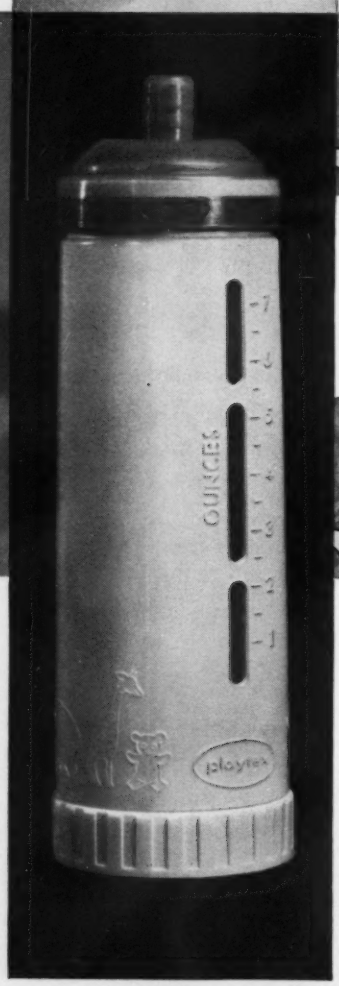
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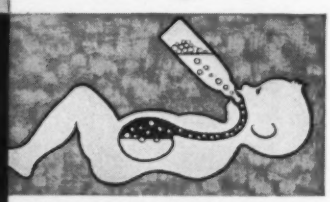


***Natural nursing action nipple*** *induces even sucking that dramatically lessens outside air swallowing and makes baby exercise his jaws. Designed to avert tongue-thrusting and other malocclusions not inhibited by conventional nipples.*

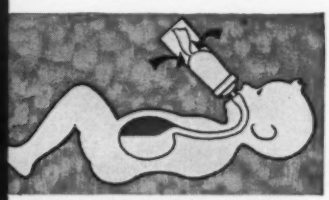


***Because the disposable bottle is pre-sterilized, it*** *eliminates the possibility of contamination through improperly sterilized bottles.*



***With conventional bottle*** *air has to get inside bottle for milk to come out. Nipple often collapses and baby has to suck harder, so more air gets into his stomach. Both overfeeding and underfeeding can ensue, along with the aerophagia and flatulence which can produce colic, spitting up, and after feeding distress.*



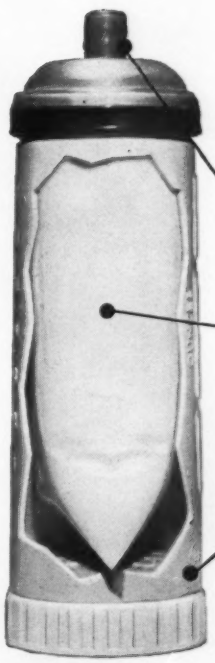
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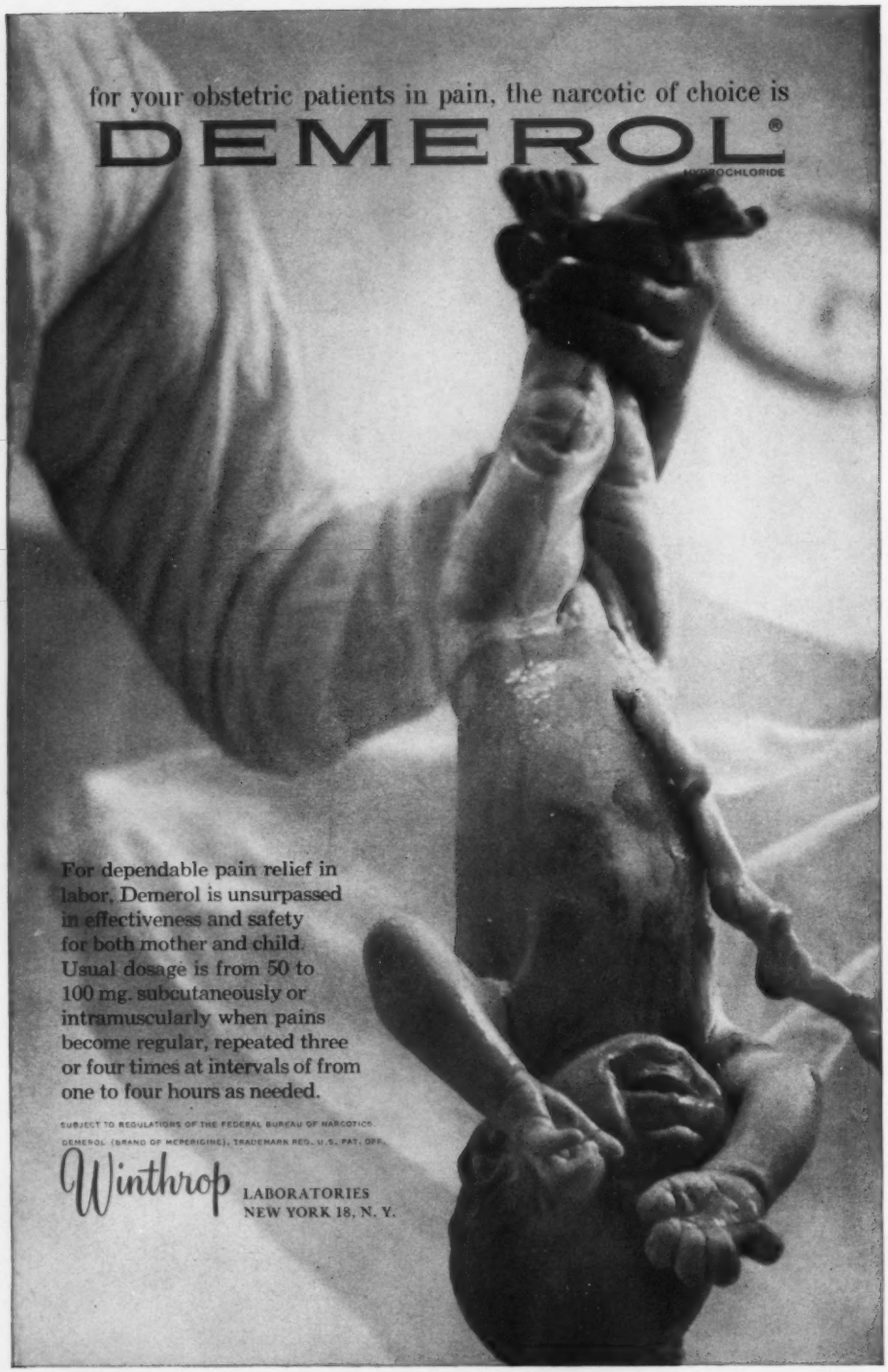

(Cut-out View)

*"Nature's Way"*

# PLAYTEX NURSER

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For dependable pain relief in labor, Demerol is unsurpassed in effectiveness and safety for both mother and child. Usual dosage is from 50 to 100 mg. subcutaneously or intramuscularly when pains become regular, repeated three or four times at intervals of from one to four hours as needed.
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# When patients are older, debilitated, or just plain finicky

## ...give them a vitamin tablet they can swallow

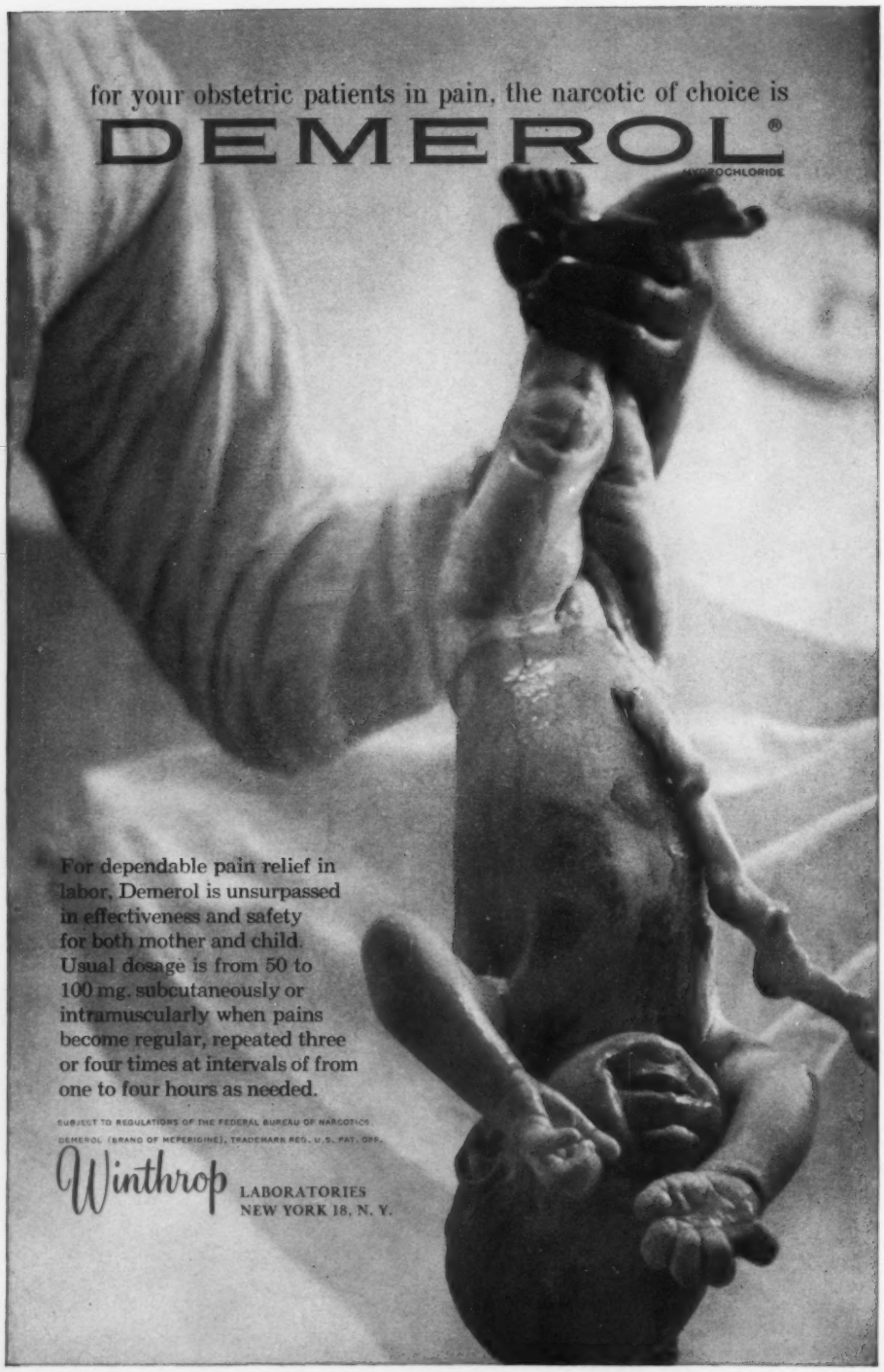
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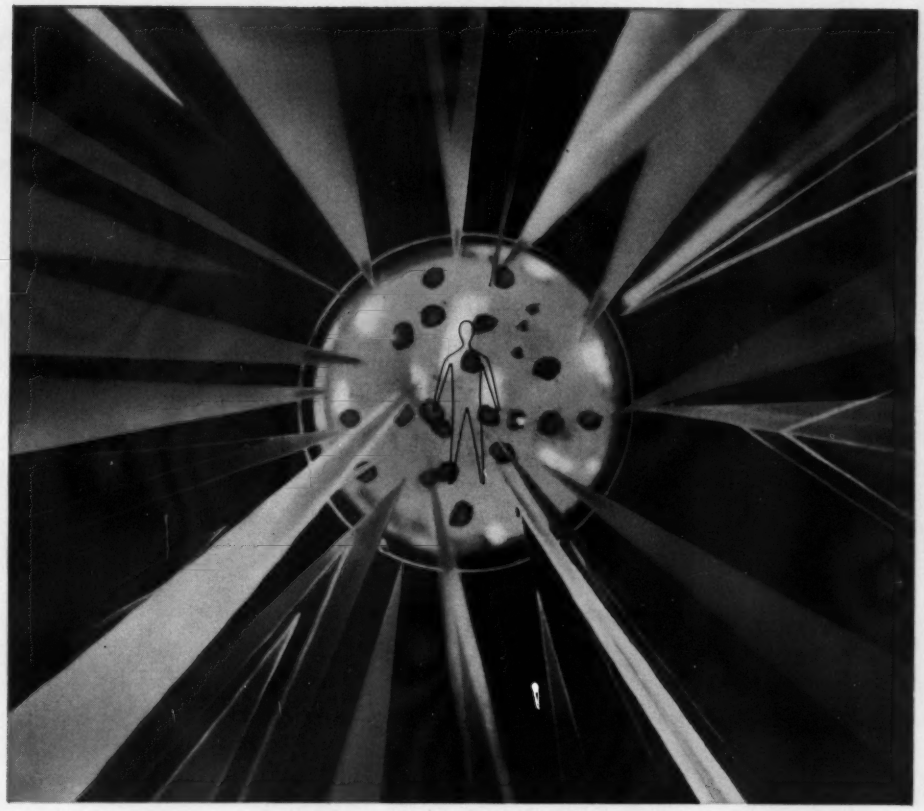
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**HARRISBURG, PENNSYLVANIA**
Thursday, November 9, 1961
The Penn Harris Hotel

**JACKSONVILLE, FLORIDA**
Sunday, November 12, 1961
The Robert Meyer Hotel

**ALLENTOWN, PENNSYLVANIA**
Wednesday, November 15, 1961
The Americus Hotel

**SOMERVILLE, NEW JERSEY**
Thursday, November 16, 1961
The Far Hills Inn

**NASHVILLE, TENNESSEE**
Wednesday, November 29, 1961
Meharry Medical College

**EDINBURG, TEXAS**
Saturday, December 2, 1961
The Echo Motor Hotel

**WACO, TEXAS**
Sunday, December 10, 1961
The Holiday Inn

***Plans for 1962 already include the following Symposia, with more being arranged:***

**MOBILE, ALABAMA**
Friday, January 5, 1962
The Admiral Semmes Hotel

**ST. PAUL, MINNESOTA**
January 8, 1962
The Hotel Lowry

**PORTLAND, OREGON**
Wednesday, January 24, 1962
The Sheraton-Portland Hotel

**ANCHORAGE, ALASKA**
Saturday, February 24, 1962
The Westward Hotel

**WINCHESTER, VIRGINIA**
Wednesday, March 14, 1962
The Lee-Jackson Hotel

**SIOUX CITY, IOWA**
Thursday, March 15, 1962
The Sheraton-Martin Hotel

**SPOKANE, WASHINGTON**
Saturday, June 2, 1962
The Davenport Hotel

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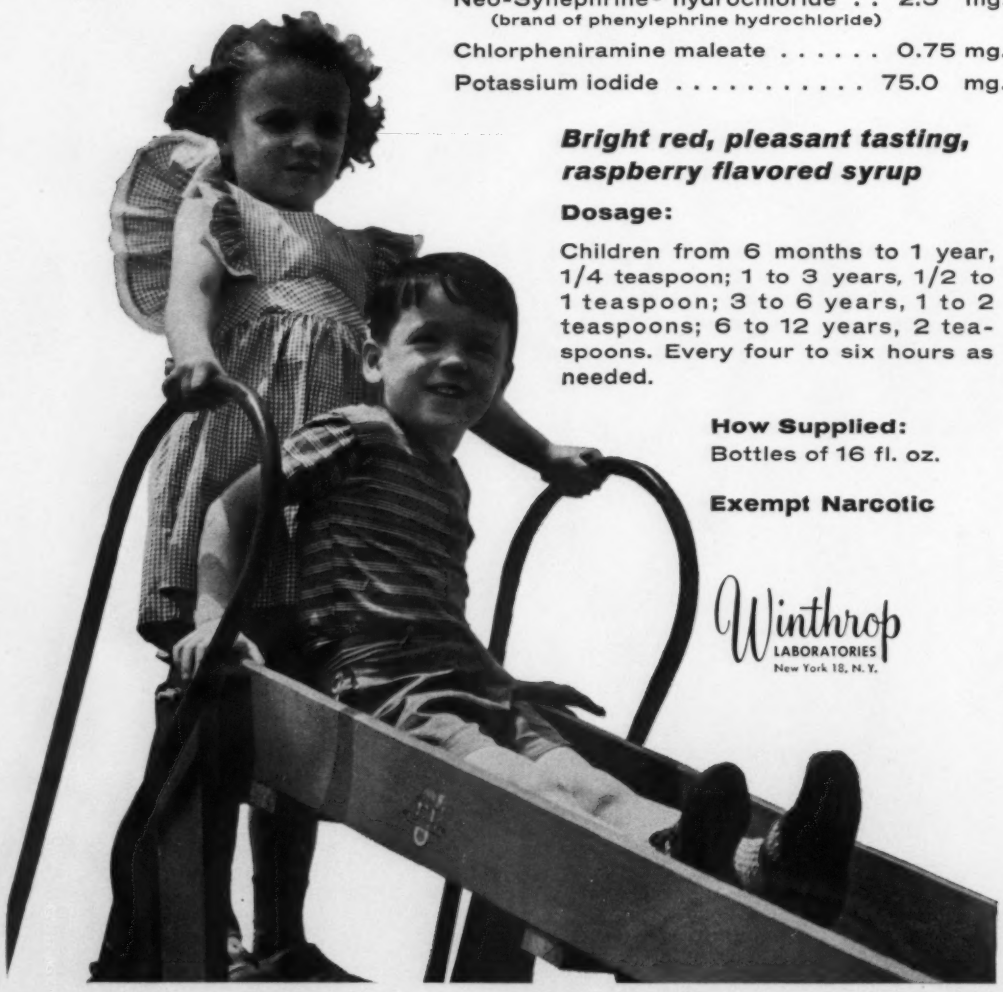
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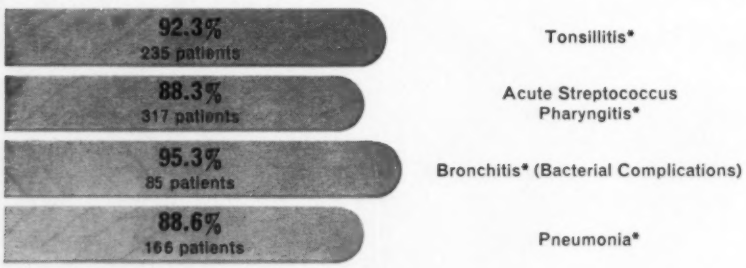
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Delaware Medical Journal

NOVEMBER 1961
VOLUME 33
NUMBER 11

# REORGANIZATION of the Department of Mental Hygiene Clinics of the State of Delaware

• **A review of the establishment of our State Mental Hygiene Clinics and their present objectives in outpatient community service will give the medical profession a concept of how to utilize such facilities for for the benefit of its patients.**

M. A. TARUMIANZ, M.D.

*On June 27, 1961, the State Board of Trustees of the Delaware State Hospital at its regular monthly meeting, complying with the Senate Bill #152, (passed by both Houses and signed by the Governor) and upon the recommendation of the Executive Committee of the Board, appointed the author as State Psychiatrist and Criminologist and Director of the Mental Hygiene Clinics of Delaware. (He has served in the same capacity since 1929.) At the same time the Board appointed the State Psychiatrist as Consultant to the State Board of Trustees. The Board approved the establishment of new offices for the State Psychiatrist in the New Castle building at Farnhurst. He was requested to prepare a separate monthly report and present the same to the Board as a separate document.*

Historical background of the Department of Mental Hygiene Clinics of Delaware: The establishment of a mental hygiene clinic was recommended by the past Superintendent of the Delaware State Hospital and discussed at the Annual Meeting of the Medical Society of Delaware in October 1927.

The preamble to the discussion was as follows:

"In our present civilization, with group life predominating, as in our schools, churches, at work, and so forth, it became a daily problem as to how the individual would use the material with which nature had endowed him, in order to make the proper necessary contacts. Every community contains many individuals who have been unable to do this. These are aberrants from the generally accepted normals, and have the same right to the help of the society as if they were actually ill. They deserve the help of society because it was through society that they were forced into

Dr. Tarumianz is State Psychiatrist and Criminologist, Director of the Mental Hygiene Clinics of Delaware and Consultant to the State Board of Trustees of The Delaware State Hospital.

their present environment, for it is society alone, as a whole, that determines our living conditions."

"It is only through mental hygiene clinics that this help can be given to the majority of the people. Since Delaware is a small state, no point of which is out of easy reach of all other points, it seems as if it would be better for economic reasons to have such service centralized, which will take care of the entire state."

**Bill Presented**

"The above plan was studied carefully, and as the result of such a study a bill has been presented to the Legislature at this session. This bill (1929) calls for the establishment of a mental hygiene clinic to be under the control of the state. It is to be hoped that every physician and citizen will recognize the importance of the passage of this bill."

The following report was read by the author, chairman of the Legislative Committee of the Medical Society, before that Society at its May 1929 meeting:

"About two years ago, at the annual session of the Medical Society of Delaware, I presented a resolution concerning the need of a psychopathic ward and a mental hygiene clinic in this State, which was accepted and approved by the Society. In connection with this we presented another resolution embodying the teaching of neurology and psychiatry to the nurses. This included two months of training in psychiatry and nervous disease in some special hospital. This particular resolution also was passed. In other words, two years ago (1927) the Medical Society of Delaware approved the establisment of a psychiatric observation clinic, a mental hygiene clinic in this State and psychiatric and neurological training of nurses."

"At the last session of the Legislature we prepared special bills in regard to those new departments. The first bill was to establish a mental hygiene clinic. The bill reads as follows:"

"An act to authorize the establishment of a Mental Hygiene Clinic under the direction and control of the State Board of Trustees of the Delaware State Hospital at Farnhurst."

"*Be it enacted by the Senate and House of Representatives of the State of Delaware in General Assembly met*:"

"Section 1. The State Board of Trustees of the Delaware State Hospital at Farnhurst is hereby authorized and empowered to establish a mental hygiene clinic to be composed of such professional assistants as may be recommended by the Superintendent (now by the State Psychiatrist) of the Delaware State Hospital. It shall be the duty of the said clinic to examine all children within the State, attending any public or private school, who are two or more years retarded, when so requested by the superintendent or other executive head of such school. The said mental hygiene clinic shall likewise undertake and carry on a continuous survey and examination of all feeble-minded. The said clinic shall have power to observe, examine, study and treat the inmates of any institution supported in whole or in part by the State of Delaware, or any county thereof, and shall likewise have power to observe, examine, study and treat any person charged with any offense in, or subject to the provision of, any court within the State, when requested so to do by the judge or judges thereof. The said clinic shall likewise have power, when requested, to extend its psychiatric services to all social agencies of the State, general hospitals and all institutions for the feeble-minded for the purpose of the discovery and treatment of mental disorders."

"Section 2. The said Mental Hygiene Clinic shall have power through the State Psychiatrist and Criminologist to apply for the commitment of any person to the Delaware State Hospital at Farnhurst under any existing or future laws of the State of Delaware relating to such commitment."

This bill was passed by the Legislature and approved by the Governor.

"The staff of every unit of the clinic will consist of a psychiatrist, psychologist, psychiatric social service worker and a clerk. There will be three centers outside of the State hospital for these units. There will be quarters in Wilmington, Dover, and Georgetown. A unit will spend certain days in various institutions. We hope to be able to examine every inmate of the Workhouse and other state or county institutions."

**Child Guidance Added**

"This Mental Hygiene Clinic will also be a child guidance clinic: It will offer expert medical, educational, and social advice concerning certain types of children who present behavior problems at home, in school, or in the community, either because of disciplinary difficulties, slow school progress or other reasons. The cases will be referred by school authorities, welfare agencies, social workers, juvenile courts, judges, physicians ,and others The clinics will be held at intervals in various communities, and a report embodying the result of the examination and the recommendation will be presented to the person who referred the case."

From transactions of the Medical Society of Delaware at their one hundred and fortieth Annual Session on October 9 and 10, 1929, held in the auditorium of the state hospital, Farnhurst, Delaware:

The author presented his address: "Thanks to the efforts of our Governor, the members of our State Board of Trustees, and the members of the Medical Society, the Legislature of this State passed a law to establish the Mental Hygiene Clinic for extramural work. This clinic has opened its activities in this State, since the middle of August, and undoubtedly is doing splendid work."

'Two years ago we only dreamed that we would have a mental hygiene clinic, and a Psychiatric Hospital for observation of mental and nervous diseases. Today this is a reality. The suggestion of a research laboratory for psychiatric work connected with this hospital might look to you as an Utopian idea, but we will endeavor to make this a reality."

"The work of the mental hygiene clinic interlaces with that of practically every public agency."

In the editorial of the October, 1936 issue of the *Delaware State Medical Journal* the following appeared.

"The mental hygiene clinic of Delaware which was established in connection with the Delaware State Hospital in August, 1929, has now found it possible to expand its activities. There are now present on its staff two fulltime psychiatrists and one half-time psychiatrist, as well as one half-time neurologist. Three psychologists are present on full service. The staff calls for six social workers, four of whom are present with vacancies for two more. With this increased staff, it will be possible to carry on constructive work in the clinic as well as in those homes where such is needed. In addition, a neuro-surgical clinic is being held monthly by Dr. Grant of Philadelphia who advises operation and treatment for those falling in the neuro-surgical field."

**Four Types Of Cases**

'The clinic is interested in four distinct types of cases:

"1. Child guidance, where the child is normal but where there is danger of the child developing certain behavior difficulties because the parents are inadequately prepared to meet problems as they arise.

"2. School children who are now showing definite behavior problems of an abnormal nature, either anti-social in character or excessive withdrawal from the group, also, such cases who are showing pre-psychotic symptoms or who present neurological conditions.

"3. Adults, both those suffering from psychogenic factors as well as those with definite organic conditions of the central nervous system.

"4. Institutional cases, both normal and abnormal."

"The clinic is interested in behavior problems, particularly in children. In those cases where indicated, intensive therapeutic work will be done to prevent adult maladjustment."

**Education Of Parents And Children**

The author in a paper published in the *Delaware State Medical Journal* in August 1949 stated:

" . . . It is true that persons begin life with certain inherent traits and tendencies. Comparatively very few are born as a diseased 'whole.' In order for this individual with such a background to achieve successfully his goal in life he must have surroundings which can help him to withstand the daily shocks and blows of his environment. To learn the application of his native talents he has to have the guidance and direction of his parents, teachers and others who become the child's immediate environment. Therefore, it is obvious that you cannot expect such adjustment of the child unless you have available adequately trained and understanding parents and teachers. In the past it has been a vicious circle. The child having a very unfortunate undesirable home envirnoment created by parents and relatives, goes to school and finds himself surrounded also by maladjusted teachers, who do not help the already confused child. This is the beginning of the child's future maladjustment which may end with serious emotional and mental outbursts."

"It seems to me that there should be research on a national scale on the matters pertaining to the education of the parents and teachers of our children."

"In recent years we have become increasingly aware of the problems of mental health and mental illness. We also recognize the fact that it is necessary to go beyond the problem of the acutely ill for the purpose of prevention. In other words we are concerned now more about mental health of the so-called normal people."

"It is true that we have to make all the necessary provisions for early treatment of the recognized acutely mentally ill and that such care and treatment should be established adequately in all public mental hospitals as well as in large general hospitals. However, mental hygiene activities should go into the routine of kindergartens, public schools, industry, the public sphere of activities, and the homes of the families."

'When a child is found, through various facilities, not responding to extramural treatment, he should be hospitalized in a psychiatric preventive center where a well organized team, composed of psychiatrist, pediatrician, psychologist, social worker, educator and others, will tackle the problem intelligently and understandingly."

"While the child is under treatment in the Center, plans for his future socialization in the community must be worked out by the staff. It would be a fallacy to allow an adjusted child to re-enter into the sphere of an undesirable existence. Such a planning program should incorporate various social outlets in additions to home, school and church. Boy scout and girl scout as well as various recreational and educational organizations in the community should be utilized appropriately."

**Governor Bacton Health Center**

"Having the above philosophy in view, the State of Delaware established the Governor Bacon Health Center primarily as a psychiatric preventive hospital for children. The Center has opened various divisions for service and we are hoping that within the next few months it will be properly organized to give the maladjusted children an opportunity to overcome their problems. The State has been very generous and has appropriated sufficient funds for such a state-wide activity and we are hoping to be able to show in a few years the justification for such an expenditure on the part of the tax-payers."

The author in a paper published in the *Delaware State Medical Journal* in August 1950 stated:

" . . . In the past twenty years, and particularly in the past five years the courts of the State of Delaware have considered

the act of crime as the possible result of some personality defect with definite emotional aberration, and for this reason have referred these cases for examination to the State Psychiatrist and the Mental Hygiene Clinic of Delaware. This group includes cases of assault and battery, indecent exposure, homosexuality, assault on children, obscene letters, arson, and similar types of offenses. These cases have been carefully studied by the court, and the majority of cases of a similar nature have been put on probation with the understanding that they should use the extramural psychiatric facilities of the State. There is a healthy tendency to use extra-mural psychotherapy in the treatment of individuals who repeatedly commit the same type of offense. Many of these cases have responded to such psychotherapeutic approach, however, some of the cases have required hospitalization. In the past we have had no facilities for accepting nonpsychotic aberrants who are criminally inclined, and we were forced to allow them to remain at large."

**For Non-Psychotic Abberrants**

"The General Assembly of 1947, recognizing the need of a department with facilities to care and treat cases of the above nature, amended the existing laws and authorized the State Board of Trustees to establish a department for 'criminally insane adults and criminally inclined juveniles."

Dr. Harry S. Howard and Mr. Leon Petty in their paper published in the *Delaware State Medical Journal* in November 1960 stated:

" . . . A considerable portion of the adolescent and pre-adolescent patients examined at the Mental Hygiene Clinics in Delaware as well as in other clinics has been involved in some type of activity which may be related to emotional difficulty and more specifically, to delinquency. This behavior covers a variety of transgressions against social patterns and undoubtedly is multicausal in origin. Thus the home situation, family economic circumstances, inherent characteristics, etc., are all involved in the etiology and in the dynamic development of these patterns of behavior. Of course, too, these deliquent patterns are followed through and have been observed at this clinic going on into the adulthood of some of the patients. These antisocial activities have been seen to continue into adult life."

"As noted above, etiologic factors are multicausal but the authors feel that since the child spends much of his waking time in school, the contributing factor of the school environment needs further consideration and evaluation."

**The Academic Problem**

"It is obvious that some children come to school well-poised, emotionally mature and ready for the interests at hand while others do not. However, the authors wish to stress the role of the school as the 'attacker' as well as the 'attacked' and the effects of the academic problem, and more specifically, the reading disabilities, on the total emotional life of the individual, on the feelings of frustration, inadequacy, and the subsequent resentment. All reading activities and all the school activities come to be seen as dangerous to the child and avoidant activities replace good motivation. Though it is obvious that a variety of reactions may take place—neurotic habit disturbance, or actingout behavior—the latter reaction is most common and creates the greatest amount of 'problem.' "

"It is the conclusion of the authors that the school curriculum plays a significant role in the development patterns and that the cessation of academic pressure, particularly as this involves reading activities (those school subjects which involve reading directly) might best be considered and a substitution of 'action' activities (such as might lead to skilled or some unskilled employment be substituted."

"It is also the opinion of the authors that special studies are needed to develop special teaching methods with children who, even in the first grade, are already showing the 'tendencies' and that these methods must cater to the 'practical' reading which would be required for 'action' activities."

### The Objective

*The objective of the present Department of Mental Hygiene Clinics under separate administration, yet under the jurisdiction of the State Board of Trustees* is the same as described above with a definite determination to increase the scope of preventive work, particularly in children and senior citizens of the State.

The preventive psychiatric work was emphasized by our Governor at the recently held Annual Governors' Conference in Honolulu when he stated: 'Our hope at present seems to lie in preventing mental illness while professionals in the various fields diligently develop methods of curing our nation's number one malady."

To visualize the above objective, the Mental Hygiene Clinics have to expand their work in all three counties as well as in the City of Wilmington. This will require additional funds to increase the staff by employing an additional psychiatrist, psychologist, social workers and clerks.

To fortify the above we would like to quote statements from the recently published book by the Joint Commission on Mental Illness and Health.

The Joint Commission on Mental Illness and Health (of which I was an active member) "received a mandate from Congress to survey the resources and to make recommendations for combating mental illness in the United States. An extensive study has been made by experts under the sponsorship of 36 organizations making up the Commission." The final report is presented in the Volume under "Action for Mental Health." This report includes the following findings in regard to mental hygiene clinics.

"Mental health clinics, operated as outpatient extensions of mental hospitals or as independent service agencies in the community, have been advocated as both a supplementary and alternative approach to the hospital care of the mentally ill. The clinics suffer from the same deficiencies that so long have plagued the hospitals—understaffing and overcrowding — except that in this case clinics do not come into being or continue to operate if professional personnel cannot be found for them, and the overcrowding is confined to their waiting lists rather than to hospital wards. The bottleneck is the same in either hospital or clinic—the professional manpower shortage."

### What Is A Mental Health Clinic?

"The N.I.M.H. defines a mental health clinic as 'outpatient psychiatric services with a psychiatrist in attendance at regularly scheduled hours who takes a medical responsibility for all clinic patients.' Under such supervision, diagnosis and treatment may be carried out by a psychologist or social worker."

"It is of general interest to note the variety of clinics fitting this description. Of the 1294 total, 280 were operated by State mental hospitals, 250 were operated by other State agencies, 300 were operated by voluntary agencies with State aid, 400 were privately operated, and 64 were operated by the Veterans Administration. Some 750 served children and adults, 400 served children only, and 144 served adults only."

"Total mental health clinic patients were estimated at 379,000, of whom 197,000 (52 per cent) were children under eighteen years and 182,000 (48 per cent) were adults. Males outnumbered females both for children and for adults."

"The 499 clinics reporting showed a rapid turnover during the year, with 60 per cent of patients being newly admitted, 10 per cent readmitted, and 30 per cent continued from the previous year. A person became a patient as the result of one face-to-face interview (or, in the case of a child, after an interview with a parent or parent substitute presenting the child's difficulty)."

"The most common diagnosis for children (36 per cent) was 'transient situational personality disorder,' meaning a reaction appearing to be an acute response

to a situation without underlying personality disturbance. But personality disorders—meaning a defect of behavior patterns with little sense of anxiety or distress—and mental deficiency—a defeat of intelligence existing since birth—were also common (21 to 17.6 per cent, respectively)."

**The Most Common Diagnosis For Adults**

"Among adults, personality disorders were most common (32 per cent), closely followed by psychoneurotic disorders, (30.9 per cent). Psychotic disorders (19.5 per cent), presented the third largest problem among adults. Psychoneurosis was defined as a disorder chiefly characterized by 'anxiety' expressed either directly or through various psychological defense mechanisms. Phychosis was defined as a disorder characterized by a varying degree of personality disintegration and failure to test and evaluate external reality correctly. Schizophrenic reactions strongly predominated among the psychoses."

"*Mental Health Clinics*: Less than a fourth of the counties in the nation have mental health clinics. The rest usually lack other supportive services as well. Where there are clinics, long waiting lists are almost universal."

"*Services to Mentally Troubled People*: Persons who are emotionally disturbed—that is to say, under psychological stress that they cannot tolerate—should have skilled attention and helpful counseling available to them in their community if the development of more serious mental breakdowns is to be prevented. This is known as secondary prevention, and is concerned with the detection of beginning signs and symptoms of mental illness and their relief; in other words, the earliest possible treatment. In the absence of fully trained psychiatrists, clinical psychologists psychiatric social workers, and psychiatric nurses, such counseling should be done by persons with some psychological orientation and mental health training and access to expert consultation as needed."

"*Mental Health Counselors*: A host of persons untrained or partially trained in mental health principles and practices are already trying to help and to treat the mentally ill in the absence of professional resources. This was made clear in *Community Resources in Mental Health*. With a moderate amount of training through short courses and consultation on the job, such persons can be fully equipped with an additional skill as mental health counselors; some might go on to become members of the mental health professional team."

"*Mental Health Consultants*: Persons who have obtained training in the mental health field, such as psychologists, social workers, nurses, family physicians, pediatricians, psychiatrists with particular interest in community services, mental health communications, and case-finding—should be available for systematic consultation with mental health counselors."

"*Community Mental Health Clinics*: Community mental health clinics serving both children and adults, operated as outpatient departments of general or mental hospitals, as part of State or regional systems for mental patient care, or as independent agencies, should be regarded as *a main line of defense* in reducing the need of many persons with major mental illness for prolonged or repeated hospitalization. Therefore, a national mental health program should set as *an objective one fully staffed, full-time mental health clinic available to each 50,000 of population.* Greater efforts should be made to induce more psychiatrists in private practice to devote a substantial part of their working hours to community clinic services, both as consultants and as therapists."

**Child Psychiatrists Needed**

*For Children*: Psychiatric clinics, providing intensive psychotherapy for children, plus appropriate medical or social treatment procedures, should be fostered and, where they exist, expanded. Of all categories of psychiatrists, child psychiatrists are in shortest supply—children being especially trying to work with and requiring the close cooperation of the parents and infinite pa-

tience on the part of the therapist. The present State aid proglam is insufficient to provide for the needs in this area. It should be expanded."

"The first step in management of any child whether he represents an acutely disturbed case from the court or some type of learning problem in school is a *proper evaluation* of the disorder. This requires a complete investigation of the home situation, the school situation, any social situation other than school, and the recreational and other peer group activities of the child. In addition, a complete health inventory must be made, including physical, psychological, and psychiatric examinations."

"Treatment of the child will ordinarily involve an intensive type of psychotherapy centered in the child, plus management of the family and environment. In many instances, it is also necessary to bring one or more other members of the family into a psychotherapeutic relationship. Often, the therapy, particularly with the family members and sometimes with the child, can be carried on by a clinical psychologist or psychiatric social worker. In this case, the therapist should have recourse to medical consultation as necessary."

"*For Adults*: The principal functions of a mental health clinic serving adults (the majority serve both adults and children) should be (1) to provide treatment by a basic mental health team (usually psychiatrist, psychologist, and social worker) for persons with acute mental illness, (2) to care for incompletely recovered mental patients, either short of admission to a hospital or following discharge from the hospital, and (3) to provide a headquarters base for mental health consultants working with mental health counselors. The function of such a clinic as a center of mental health education for the public is of incidental importance, and should preferably be left to other agencies."

'The need for an increase in the number of mental health clinics is obviously extreme, inasmuch as less than a fourth of the counties in the nation have them. Where clinics exist, the waiting lists are usually so long that they tend to defeat the clinic's purpose of serving the community."

## RESUME

The following is a resume of work performed by the Mental Hygiene Clinics of Delaware during the year ending June 30, 1961:

| | |
|---|---|
| Old Cases Carried over | 693 |
| New Cases | 825 |
| Old Cases Reopened | 159 |
| Total Cases | 1677 |

The above work is divided among the following four divisions:

| | |
|---|---|
| Psychiatric Division (*Total new and reopened cases*) | 759 cases |
| Psychology Division (*Total new and reopened cases*) | 703 cases |
| Social Service Division (*Total new and reopened cases*) | 449 cases |
| Evening Clinics | 106 cases |

The present staff is composed of the following:

| | *No.* |
|---|---|
| Director, a fulltime psychiatrist | 1 |
| Assistant Director, (fulltime psychiatrist) | 1 |
| Clinical Director, (fulltime psychiatrist) | 1 |
| Chief Psychologist | 1 |
| Psychologists | 2 |
| Chief Social Workers | 2 |
| Social Worker Aides (one fulltime and one part-time) | 2 |

Vacancies on the staff are as follows:

| | *No.* |
|---|---|
| Psychiatrist, fulltime | 1 |
| Psychologists, fulltime | 2 |
| Social Workers, fulltime | 2 |
| Social Worker Aide, fulltime | 1 |

## CLINICAL APHORISMS

Do not swallow the "valediction" approach to tuberculosis eradication — there are still many "semi-gluteal" attempts at tuberculosis control. The "behavioral scientists" do not treat the patients. *Robert V. Cohen, M.D., Clinical Professor of Medicine*, Temple University Medical Center Bulletin.



# EXPANSION
# of the Delaware Mental Health Program

**• Replacing of facilities, expansion of programs and opening the hospital staffs to private practitioners are some of the methods being recommended to implement progress.**

CHARLES K. BUSH, M.D.

Although Delaware has stood near the top of the states for a number of years in the services which it provides for the mentally ill and the mentally retarded, it is impossible for it to stay among the leaders unless progress is continually made. Other states are adopting newer, proven methods of treatment and are experimenting with other ideas which may, any day, revolutionize our concepts of the management of mental and emotional problems. To remain static is to lose ground steadily when others are forging ahead.

In order to remain in the top group, Delaware must have:

(1) More professional personnel;
(2) Better physical plants;
(3) A more diversified program which will give each patient exactly the type of treatment which is best for him, at the earliest possible moment;
(4) Research into newer methods of treatment and diagnosis.

Dr. Tarumianz, my predecessor, has laid a strong foundation upon which this superstructure must be built.

There is a shortage of adequately trained professional personnel at all three institutions. The shortage is most noticeable in the fields of medicine, psychology, nursing and social work, but other types of therapists are also needed.

The shortage of physicians is most acute in the grade of senior or supervising psychiatrist. At least one psychiatrist in this category is needed at both Stockley and Governor Bacon and several are needed at Farnhurst. These positions require a psychiatrist who has passed the Board examinations in psychiatry of the American Board or its equivalent. Doctors who have passed their Board examinations are not usually content to remain in state service unless compensation is adequate and there are enough fringe benefits and professional contacts to make the job as attractive as private practice. Job satisfaction is extremely important if good people are to be retained.

Psychologists with Ph.D. degrees are needed at two of the institutions to strengthen departments which are operating at a less than satisfactory level. In addition to testing new patients and retesting those who have been in the institution for several years, psychologists are needed to conduct group psychotherapy

Dr. Bush is Superintendent of the Delaware State Hospital, Governor Bacon Health Center, Hospital for the Mentally Retarded and Director of Daytime Care Centers for Severely Retarded Children.

and to assist in the research program. These last named functions have been virtually eliminated because of the shortage of staff.

All patients should have nursing supervision around the clock, but many services have registered nurses on duty on only one shift, with one registered nurse giving only minimum supervision to several services during the remainder of the 24 hours. This places additional responsibilities on attendants and the already overworked medical staff. Psychiatric nurses are trained to observe patients, to foresee trouble and prevent its occurrence, thus saving time for all personnel and helping the patient to make a better adjustment. Wards with constant nursing supervision are usually cleaner, better organized and have fewer "incidents."

#### Social Workers Important

Social workers are important in getting patients admitted properly to the hospital, but they are more important in getting them out of the hospital and keeping them out. When patients are sufficiently recovered or improved, it is the job of the social worker to prepare the family for the patient's return, to find a foster home or boarding home if there is no interested family, and then to supervise the patient after he leaves the hospital by regular visits and counselling. When a patient has to return to the hospital because of further difficulties, it is often because he has not had sufficient help in his attempt to adjust to normal living outside the institution.

The replacement of obsolete and outmoded buildings at Farnhurst and Stockley has started, but there is much more to be done. New facilities for the receiving, medical-surgical and geriatric services are needed at the State Hospital at Farnhurst, and all the residential cottages at the Hospital for Mentally Retarded at Stockley should be replaced as soon as possible. Consideration must be given in the very near future to the establishment of another hospital for the retarded in the northern part of the state and one for the mentally ill in the southern part of the state. The new hospital for the mentally ill should probably start as an acute treatment center of perhaps fifty beds with the ultimate idea of a hospital offering all services but not exceeding 200 beds. The hospital at Farnhurst could probably be cut to 1200 beds by that time.

#### Travelling Distances Present Problem

Relatives of patients rightfully complain of the long distances necessary to travel to visit the patients when they are at the other end of the state. A small unit for the retarded in New Castle County would overcome some of the complaints and would increase the possibility of the family maintaining an interest in the patient. Since there is a waiting list for admission to the Hospital for the Mentally Retarded and since it is undesirable to increase the size of the hospital at Stockley, a 100 bed unit in New Castle County would serve to eliminate the waiting list, place many patients closer to their homes and make it unnecessary to further increase the bed capacity of the existing hospital.

What to do about the Governor Bacon Health Center is still debatable. Originally conceived as a hospital for emotionally disturbed, pre-psychotic and psychotic children, it has become an institution for many types of patients—crippled children and adults, epileptics, alcoholics without psychosis and bed-ridden geriatric cases. If the Welfare Home could care for the geriatrics and crippled patients in their expanding facilities, the beds thus liberated could be used to much better advantage in caring for the emotionally disturbed and psychotic children. In time, the alcoholics could probably be absorbed in the State Hospital at Farnhurst, thus returning the institution to the purpose for which it was originally planned. Some replacement of buildings will be necessary but cannot be intelligently planned until the future of the institution is determined.

**Suggested Programs To Implement Progress**

New programs that should be started as soon as possible include:

(1) A day care hospital at Farnhurst for patients who need a full daytime program of psychotherapy, occupational therapy, recreation and vocational training, but who would be able to be in their own homes at night. Such a program would cost about 50 per cent of the amount that full-time in-patient service would cost, would be available to those patients that require more than out-patient service but less than full hospitalization and could be used as a stepping stone for those in-patients that are almost ready to be discharged to out-patient care.

(2) A night care unit for those patients who can continue in their regular employment but who need treatment which can be given in the evening hours. This could also be used for patients who are being considered for discharge if they can make an adjustment to living outside the hospital. They could work outside the hospital, live at the hospital on a full pay basis and then be discharged when they have demonstrated the ability to hold a job and get along without too much supervision. Nightly group and individual psychotherapy, with other therapies used when needed, would be available to this group.

(3) Whereas the first two programs could be used at all three institutions, the third one would be most applicable at the Governor Bacon Health Center. This would be called the "week-end" hospital and would be mainly for those alcoholics who seem to have little difficulty during the week when they are working, but seem to revert to the bottle when time drags during the week end, or when inter-family difficulties may make abstainence difficult. These patients would come in on Friday afternoon and leave Monday morning and would have a full program of activities during the weekend.

(4) An emergency home visit program should be organized which would be available to any physician or law enforcement officer in the state. A team, consisting of a psychiatrist, a nurse and a social worker would be on call at all times to visit the home where there is a prospective patient for one of the institutions under the State Board of Trustees. This team, after interviewing the prospective patient and the relatives in their normal environment, would decide when the person needed in-patient care, day care, out-patient care or some guidance from the family physician or minister. This would perhaps save many admissions to the hospital and would assure that the person would receive necessary care at the earliest possible time.

(5) The matter of open staffs at the hospitals was freely discussed in a recent symposium at Philadelphia and the idea seems to have considerable merit. Psychiatrists in the community would be appointed to the attending staff of the hospital, could continue to treat their private patients who were admitted as in-patients and would also contribute some time to indigent patients in the hospital. General practitioners, who were interested in furthering their knowledge of psychiatry, would be appointed to the courtesy staff, would be able to follow their private patients during their hospitalization, would be invited to attend lectures and participate in other professional activities at the hospital and would donate some time to the physical care of indigent patients.

Obviously, to inaugurate these programs it will be necessary to increase the professional staff at the institutions and this means an increase in money, up-grading salaries and improving facilities. The administration and the Board of Trustees of the hospitals will need the help and encouragement of the medical societies, their individual members and all groups outside the profession who are interested in the best treatment for the mentally and emotionally ill and the mentally retarded.

# PSYCHOTHERAPY --

# *URGENT*

• **Four cases handled on an out-patient basis have been selected by the author to demonstrate that early activity on the part of both the patient and his therapist can result in favorable reactions.**

HARRY S. HOWARD, M.D.

With the increased acceptance of mental illness as an illness and not as a failure, there has been an increased demand for psychotherapy and an increasing variety of psychotherapists.

Starting with the orthodox psychoanalyses with its tremendous time consumption and its subsequent lack of availability of therapists there have been innumerable psychotherapists, directive and non-directive, etc., with the added number of fringe types, all seemingly designed to confuse therapist and patient as well.

One is struck by the frequently offered assumption that most psychiatric patients, psychotic, neurotic, etc., are so deficient in ego strength that the therapist must, from the beginning, serve in locus parentis and with the added assumption that the patient will have to be "carried." While the thought that the physician should serve as the mirror of the patient's personality may be satisfactory where long drawn out therapy is anticipated and possible, it is the opinion of the author that this is impractical in the treatment of the average emotional problem when time is not available or when the patient's neurotic symptoms or character disturbances are proceeding rapidly downhill. This technic fails to consider the patient's actual "strengths" and current situations.

Dr. Howard is Assistant State Psychiatrist and Assistant Director of Mental Hygiene Clinics of Delaware.

It is indeed surprising to find that many patients have, by the time they come to treatment, a basic "transference readiness' which can be developed and utilized very rapidly and in which the patient's ego strength is utilized fully. The author feels that once the patient's symptoms and defenses are understood, a great deal of interpretation is advisable. To undertake a treatment procedure which calls for a long history, long drawn out and studied relationships with passive and non-directive technics, in a disturbed neurotic, or, a depressed and possibly suicidal individual, or a serious alcoholic, is as effective as a conference on how best to put out a blazing fire.

In twelve years of serving in a clinic setting in an atmosphere where diagnosis, therapeutic recommendations, and therapy must be made urgently, the writer has found it necessary to develop time saving techniques which have, by and large, worked out satisfactorily.

The basic premise utilized has been that the patient has a degree of ego strength and that he must be picked up "where he is." With this in mind, then, even though a complete history is readily available, and frequently including a good psychological examination report, the patient is asked to give his chief complaint in detail, his background, and his current reaction to those people who are close to him. However,

this is done essentially to establish rapport with the patient and he is not allowed to ramble. In many cases an attempt to interpret conflicts and resistances is made, even in the first interview. The patient is invited, informally, to discuss these early interpretations and in this manner a considerable amount of "activity" is developed for both the patient and the therapist with the patient having been given the responsibility to look at his conflicts and so to increase his degree of self-esteem. He begins to think about his problems rather than his symptoms.

In some cases, where there appears to be a more than average degree of intelligence and fair ego strength, the patient is asked to write a report, in the form of a letter, of his first interview and of his (or her) reactions to it. The writer uses this innovation (even though the patient is told that he need not mail, or even bring the report in unless he wishes to do so) in order to quickly crystallize patient-therapist reactions and to create an emotional involvement with his problems (and not with his symptoms).

Occasionally patients have spontaneously followed up this "report" with other "reports." Occasionally, too, this has been interpreted to the patient as a measure of that patient's wish to "perform" and so to be allowed a dependent relationship.

As has already been mentioned, activity in terms of challenging all defenses and reactions by the therapist constitutes the "core" of the treatment philosophy and the work is never allowed to "go dead." Generally speaking, therapy is brief and the results are gratifying.

A few brief illustrations follow. Some have been oversimplified:

Case A: Alcoholic and gambling addict. "A" was referred through the efforts of his landlady and her husband. He had been married twice, was divorced from his first wife and separated from his second wife. He had been a successful automobile salesman. His income appeared to be adequate. His first wife had, in her own right, managed a successful business. His second wife continued to work throughout their brief marriage. His history was one of serious weekend drinking. His contributions to his bookies used up the remainder of his income and a good share of his wife's as well. He was obviously a serious oral character. As was evident, efforts in his behalf by friends proved fruitless.

He, himself, while verbalizing some concern and anxiety regarding his situation, actually came reluctantly and apparently only to please his friends. He spoke of the loss of his jobs, the estrangement from his wife and child, but he was not really "involved." Instead he seemed to be anxious to tell the writer that his friends were interested in him, that his landlady was kind to him and, indeed, treating him as one of the family.

The interpretation made at this first session was that he seemed to feel content with the privileges of the kitchen and was willing to forego the privileges of the bedroom. (His drinking suggested that indeed he was not happy with the arrangement.) The therapist rejected this lip service kind of defense and insisted that the patient become involved with his treatment. Though his friends offered to pay for his treatment this, too, was rejected by the therapist, and "A" was made responsible for the cost of his treatment. "A" apparently startled by this interpretation and management stopped drinking, immediately made a successful attempt to get his job back and moved in the direction of re-establishing his home. Unfortunately, the success story ended four weeks later for reasons unknown but probably related to conflicts which developed when the therapist had to cancel an appointment.

The case is of interest in that it illustrated early "activity" on the part of the therapist in a character disorder which promised little in the way of prognosis. Of interest, too, is the fact that the total

amount of time spent with him was approximately four hours. It should be added that though the therapist has had no further contact with him, and though he had a "break," he is again employed and working.

CASE B: "B" was seen in consultation with another agency. Thus, he could be seen in only one session and treatment recommendations were requested.

He had a history of stomach ulcers over an extended period of time and had been treated conservatively with diet, antacids, etc. No one had attempted a psychiatric approach prior to that time.

He was invited to give his history in the manner already discussed and after a brief period in which rapport was established, the emotional component was suggested in terms of his "griped gut." He asked for an explanation and in so doing revealed a reasonably strong ego. His reaction to the "intellectualized" explanation was "why hadn't someone told me this before?" and an apparent relaxation.

The case was of particular interest because the patient was able to use a good residual ego strength to accept an unusually early interpretation with an obvious reduction in anxiety.

Total time actually used was fifty minutes.

CASE C: "C" had been referred to the clinic by his family physician. His chief complaint was ejaculatio praecox.

Background information revealed a dominating and aggressive mother with a fearful and passive father. "C" had, himself, been married twice, each time to an aggressive and demanding woman. His first marriage ended in divorce when his wife became involved in an open affair and when he, himself, had suffered a serious economic setback.

His "letter," quoted in part, stated "I am afraid our interview started with my being quite taut, nervous—ill at ease. I can see that some of the things left unsaid were as leading as those spoken—my 'getting even,' the feeling of wanting to be mothered and yet rejected—and though I didn't like to admit it, this 'mothering bit' does make sense, and to accomplish it I have been using the 'tired boy' device — headache, indigestion, etc. . . ."

Improvement was seen after the first interview and maintained fairly well. He was able to "stand up to" his wife and to make a decision regarding a change in his employment. Sexual function was quite satisfactory.

The case is of interest, again, in that "C" was able to utilize his good "intelligence" in working through his problem and quickly translating symptoms into conflicts.

CASE D: "D" was referred to the clinic by his physician essentially because of "depression." He was gainfully employed as an unskilled worker and had a history of having been a steady dependable worker over a period of many years.

The onset of his symptoms dated from the termination of a common law marriage to an older woman. ("The mother figure had rejected him.")

He had, in spite of his good working habits, marked feelings of inadequacy with an over-all need to "beg" acceptance from his peers on their terms, and it was obvious that they were taking advantage of him. Indeed, it was this situation which was first attacked as a problem when the patient confided that he had loaned a considerable amount (for him) of money to a friend and that the friend was taking no steps to return it as promised. He was constantly "doing favors" for people who had learned to expect them and without return or gratitude. Aggressive action in these and similar situations was encouraged and acted on by the patient with a considerable increase in his self-esteem and with the disappearance of the depression.

# DYNAMIC PLANNING

# in the Field of Mental Retardation.

• **The value of a society could be judged by the extent to which it cared for those of its members unable to care for themselves.**

MICHAEL ELYAN, M.D.

In 1946 the American Association on Mental Deficiency estimated that 7% of the population is mentally or intellectually deficient.

If we are to plan dynamically for the rehabilitation of the mentally handicapped, we must have positive goals in view. These should correlate prevention, diagnosis, research, and habilitative procedures. Hope for eventual eradication of mental retardation lies in research, which should be both of clinical and laboratory nature.

In recent years, there has been a profound and significant advance in respect to the treatment of the mentally subnormal. Light is at last penetrating the darkness.

The psysiotherapists, speech therapists, psychiatrists, sociologists, orthopedic surgeons, neurosurgeons, and pediatricians are all contributing their quota towards the rehabilitation of the mentally handicapped.

The defects ocurring in many inborn errors of metabolism are now being identified. To give a few examples:

(1) In *Congenital Galactosemia* the underlying defect is the absence of the enzyme phospho-galactose uridyl transferase (Isselbacher 1957) which catalyses the first stage of the conversion of galactose-1-phosphate to glucose; this results in an inability to metabolize galactose, and causes intolerence to milk which characterizes the condition. The diagnosis is established by the finding of a markedly elevated galactose tolerance test and galactose in the urine.

In order to prevent the development of mental retardation, hepatic damage causing jaundice, hepatomegaly, splenomegaly and cataracts, early diagnosis and treatment is mandatory.

Treatment is effective if the patient is given a completely lactose free diet.

(2) *Phenylketonuria* is due to a deficiency of the hepatic enzyme phenylalanine hydroxylase which normally transforms phenylalanine to tyrosine.

In Phenylketonuria there is progressive brain damge and severe mental deficiency. It should be borne in mind that the ferric chloride test is not positive until after the third week. This test is only a rough indication of the presence of phenylpyruvic acid. The serum phenylalanine should always be estimated.

Treatment consists of giving diets low in phenylalanine, such as Lofenelac beginning in the neonatal period. This can prevent the development of mental deficiency.

Concomitant with the work in the field of inborn errors of metabolism, there are

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being discovered a number of disease entities which are often associated with mental retardation and which appear to be due to the presence of an abnormal number of abnormal complement of chromosomes in metaphase nuclei of the involved patients. Mongolism is probably the most common of these hypersomic conditons. Most mongoloid patients who have been studied have 47 chromosomes. However, there have been reports of mongoloids with typical features who have 46 chromosomes.

Special techniques have recently become available whereby it is possible to detect patients with chromosomal abnormalities. Such patients are frequently mentally retarded and accordingly it would seem wise to apply these techniques (buccal smear, blood smear for interphase nuclei and bone marrow and tissue culture for metaphase nuclei) to all patients in which any of the following are present:

1. The history indicates that the parents were of advanced age at the time of the patient's conception; or that the parents were exposed to certain drugs, irradiation or viral diseases during gametogenesis or pregnancy.

2. A history of mongolism, sterility or mental retardation of no known definite genetic type in other members of the family.

3. The presence of color blindness, or other known sex-linked characteristics, in female patients.

4. The presence of marked or multiple congenital abnormalities.

5. Abnormalities of the reproductive system or of secondary sex characteristics including sterility and amenorrhea. (Stimson, Cyrus W. 1961)

It seems clear that future investigations in the field of genetics will offer a greater understanding of mental retardation.

It is accepted now that rehabilitation for the moderately sub-normal should motivate a two-fold purpose, namely occupational therapy and the training in the art of living. One does not help an adolescent to deal wisely with money by always handling it for her, how to choose clothes by ordering them in bulk from the stores, how to deal with sex problems by complete segregation, how to travel by sending her under escort, or how to cope with all the problems merely by a system of punishments and rewards. At all costs, regimentation must be avoided. Starting with simple journeys on foot to explore their neighborhood until they can cope single-handed with quite frequent journeys by train and bus, learning to use the telephone, how to carry verbal messages reliably, and how to do the shopping; these are all very important procedures. In addition, a counselling service which anticipates, deals with, and smooths out difficulties is a vital service to the sub-normal.

In planning rehabilitation procedures, basket making, mat making or other works of art are adequate for the permanent custodial sub-normals. But such occupations are seldom regarded as work by the subnormals who are being trained to return to society, these occupations are really only hobbies to be pursued in unoccupied hours. Traditional institutional methods of training are not only limited in scope but often out of touch with reality. There is urgent need for pre-industrial training which caters for production of a multitude of different type of goods, and aims at teaching the virtues of time-keeping, general and work behavior. In fact, it is essentially a training for those who will eventually become unskilled workers and should have some experience in operating simple modern industrial machines, while always avoiding a factory atmosphere.

Some degree of self government should be implemented in small groups of patients, which is surely the most effective way to instill a sense of responsibility.

Let us look at a few of the objections that are raised. It is asserted that the

mixing of the sexes in institutions will sap the foundation of common morality. But an approach to breaking down segregation must be implemented if we are to train the sub-normal for a possible return to ordinary life. Moreover, recent experiments in many institutions throughout the world have proved that free asociation between both sexes in those suffering from mental retardation does not lead to dire consequences so frequently predicted. In such an experiment carried out at a hospital in Norway not one single girl became pregnant, though circumstances might have facilitated it.

Futhermore, such integration replacing the massive wall of tradition and prejudice will serve the purpose of overcoming a great deal of homosexuality which exists so frequently in the strictly segregated institutions.

It is very vital that adequate monetary reward be given for services rendered by the patients within the hospital. This enables them to purchase the things they like. Moreover, in the higher-grade sub-normals, there is no reason why they should not dine out at restaurants. In Norway where it is freely practiced it does not arouse any animosity among the ordinary public or the waiters. In some of the hospitals in Norway many patients of all ages have for years kept company. The men and women give each other presents and indeed on birthdays and other celebrations the female partner will often make special treats for the male. At such celebrations the staff are invited to participate. The patients are well adjusted and no special sex education is given. In some of the institutions in Norway former patients have been happily married for quite a while and are earning a good living.

In Birmingham at Monyhull a social club has been established with membership open to both sexes. The club meets one night per week from 7 to 9 in the canteen or assembly hall. Everything stops for tea and biscuits at 8 o'clock. The tea-making, serving, and washing up is done by the men and women on a rotating basis. The committee members choose their own secretary. Membership is cancelled if any patient loses his job in the hospital.

Compared with the normal youth clubs, this club is not only easier to run, but the behavior of the members is definitely superior to outside youth clubs. Not one single incident resulting in the expulsion of a member on account of relationship with the opposite sex has occurred.

Tizzard (1960) carried out a very important experiment this year in England. He based his work on Doctor Lyle's observation "that institutional children are particularly retarded in all aspects of knowledge and speech and understanding as compared with similarly mentally handicapped children who live at home. The older the institutionalized children, the greater becomes the discrepancy between their achievements and capabilities and those of comparable children brought up in their own homes. It is clear," he continued, "that institutional care warps and stunts the development of already seriously handicapped children.

Tizzard selected 32 children, divided into 16 pairs consisting of 9 boys and 7 girls. Half of them were mongoloids and the rest suffered from severe brain injury. Their average age was seven and a half years and their average I.Q. was less than 25 points. In personal independence they averaged about 3½ years. He placed them in a nursery in the form of small groups of families and they were cared for by "house mothers" whose training was in the management of problems of normal children. They were not nurses. Thus, as far as possible the home atmosphere was implemented. The whole program was based on nursery school lines, with no formal curriculum.

The children by and large selected their own play materials and activities in conformity with their interests. There were

also group activities. The children helped about the house, just as normal children do, making beds, setting tables, etc. Of course, opportunities for creative activities such as painting, clay, sandpits, doll-play, boxes and blocks were carried on.

When these children first entered, they were largely mute, nor could they play with one another. Most of them would hit out, bite and have violent rages. They showed no preference for any one adult. After six months their pathological behavior improved greatly. They can now play with other children and are able to do a lot more for themselves. They are affectionate, happy children, busy and interested in what they are doing. They are energetic and full of fun. After one year the children increased by eight months in mental age, as against a similar group of children suffering from the same conditions who were still residing in an institution and who showed no improvement in their mental age.

This experiment demonstrates that it is possible to motivate such a group of children to live much richer and happier lives, resulting in greater intelligence and greater maturity. They become less fearful and neurotic and are more socially competent.

Inevitably some return after discharge following a spell of successful living in the community. But after all we don't consider a person who has to return to a mental or general hospital as hopeless, so why be so stringent in our criteria for the subnormal. Many normal folk require tonics, stimulants, sleeping pills, rest cures, etc., to maintain working efficiency and breakdown after recovery. Large numbers of discharged sub-normals lead useful, quite uneventful lives. If an odd one hits the headlines by committing a serious crime, it doesn't mean that there are hordes of criminals being let loose to destroy us. One must anticipate the occasional breakdown in the sub-normal too.

The importance of environmental and social opportunties are of vital significance. In England almost 60 per cent of the population have I.Q.'s slightly below the average normal of 100, yet most are engaged in gainful occupation and are well adjusted people. Those with I.Q.'s of 50-70 are usually casual laborers, those with I.Q.'s of 85-100 manage to hold down simple commercial jobs. Of course, when crises or unemployment occur these often fall by the wayside.

An American investigator carried out a follow-up for 15 years of discharged subnormals all with I.Q.'s' below 70. There were 151 sub-normals. Approximately 80% married and 21% were divorced, which is below the national average of the United States. Their homes were mostly clean, most had jobs. Eighty-three per cent of the group were economically independent and about half had been in the same employment or type of employment from 3 to 15 years. Most were doing unskilled jobs. Approximately 80% had children. The school records of these children showed nearly all to have satisfactory careers, their I.Q.'s average 95 which is only very little below average normal of 100.

In a Christian society it is our duty to ensure that handicapped children are given the best opportunities that medical research can offer and that their functional potentials are developed to the utmost limit of their capacities.

Francis Thompson wrote:

KNOW YOU WHAT IT IS TO BE A CHILD?

*It is something very different from the man of today.*

*It is to be so little that elves can whisper in your ear. It is to turn pumpkins into coaches and mice into horses, lowliness into loftiness, and nothing into everything. It is to live in a nutshell and count yourself king of infinite space.*

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# MENTAL RETARDATION:

## A Family Portrait†

**• The following family portrait is offered as an aid in understanding the whole family constellation when dealing with the retarded individual . . ."**

SHELDON W. WEISS, Ph.D.
LEON E. PETTY, M.S.
EDITH FINGERT, M.S.

The etiology and treatment of mental retardation has been the subject of much investigation and research for the past several decades. In addition to numerous physiological and genetic abnormalities of the central nervous system, there are also a multiplicity of contributory factors such as specific infections, allergic responses and other prenatal, perinatal and postnatal conditions. Also there are important psychological factors which must be considered in any discussion of the attitudes, etiology, prevention and understanding of mental retardation. The following family study is reported in an effort to illustrate the various facets of the problem of mental deficiency.

This case was referred to the State Mental Hygiene Clinic from the Child Welfare Division of the Department of Public Welfare in June, 1959. It concerns the children of Richard and Anne Smith, parents of Richard, Jr., born March 24, 1952; Morris, born August 19, 1953; Peter, Born April 24, 1955; Wilbur, Born August 15, 1956; Anthony, born October 24, 1957 and Loretta, born May 23, 1959. The referral stated: "We are requesting evaluation and recommendation concerning the best possible plans for the above named children. Custody of these children was awarded to the State Department of Public Welfare in a Family Court hearing in June, 1959, and they have been placed temporarily in foster homes."

The worker stated that: "These children have been victims of severe physical neglect for most of their lives. They have been living with their parents in a small house, which is verminous and extremely filthy. They have been almost constantly dirty, have seldom been diapered and have been taught no toilet habits. Richard has been attending Opportunity Classes and we understand from the school that he may be eligible for the Hospital for the Mentally Retarded. He takes a protective attitude towards Peter and has a close relationship with Morris. Morris seems to be the most responsive child and seems to have a better understanding of the situation at the time of separation. He has been attending kindergarten and on intelligence tests seemed somewhat higher than Richard. He is a rather independent child and does not seem too close to the other children."

"Peter appears to be very limited, is not toilet trained, and seems to have no understanding of what is happening to him. He

† All names have been changed to insure anonymity

Dr. Weiss is Chief Clinical Psychologist and Mr. Petty and Mrs. Fingert are Staff Psychologists, Mental Hygiene Clinic, Farnhurst, Delaware.

displayed no distrust of the worker and tends to follow the crowd. According to his parents he is quite protective of Wilbur. When he was a year old Peter received a complete workup at the Delaware Hospital and he was felt to have brain damage or a neurological condition. He appears to hold his head to one side since being in his present foster home, he has been observed trying to walk on his head. He scratches the walls, grunting and generally behaves in an animalistic manner."

**Case Histories Of Children**

"We have found both Wilbur age 3, and Anthony 1½ years old, very irresponsive children. Neither of them are toilet trained. Wilbur cannot walk and still uses a bottle occasionally."

The first of the Smith children to be seen for psychological examination at the Mental Hygiene Clinic was Richard, Jr. At the time of psychological testing he was 7-2 years of age and attending the first grade of Opportunity School. The examiner reports that Richard: "Is quite an unprepossessing looking boy, inappropriate grin, with marked clumsiness and untidiness and a noticeable speech defect. He was shy and timid, his attention span was short and he exhibited marked emotional lability. A mental age of 3-1 years was obtained with an I.Q. of 49. A previous examination, in January, 1958 by the school psychologist reported a mental age of 2-6 with a chronological age of 5-9 and an I.Q. of 43. As can be seen there has been some improvement. However, this boy, as can be observed, would appear to fit into the program provided by the Hospital for the Mentally Retarded at Stockley."

The psychiatrist, at the conclusion of his examination, reported: "Richard had his hands in his mouth, and did not talk much but he did show an infantile kind of speech. Nevertheless, he seems to be a likeable child. Though there undoubtedly has been some improvement in his condition, since he was first placed in Opportunity School, and though there may be some possibility that he will improve somewhat, it is our feeling that he would still remain mentally retarded and that institutionalization at the Hospital for the Mentally Retarded at this time seems to be indicated." Richard was admitted to the Hospital for the Mentally Retarded on November 18, 1959.

The second child, Morris born in August of 1953 at the time of examination was 5-10 years of age. The psychologist reported: "That Morris willingly entered the testing situation and was cooperative. He exhibited some slight speech difficulty but this did not seem to grossly affect his ability to communicate his wants to others. Morris was unable to give his date of birth or his age and initially stated that he did not attend school. However later on, the patient discussed some of his activities at kindergarten. Morris seemed unaware of the fact that he was living outside of his real home. In fact, he stated that "my mother is going to find another clean house and then all of us will be back together again." Psychometric examination revealed a verbal scale I.Q. of 74, a performance scale I.Q. of 74, and a full scale I.Q. of 71." It was the examiner's impression that the patient could perhaps display a little better potential but that he should remain in kindergarten for at least another year.

Morris was again seen for psychological examination in August, 1960 at which time his chronological age was 7-0 years and a mental age of 4-11 was obtained during this testing session yielding an I.Q. of 75. The psychologist reported: "Although in a year's time there has been no drastic rise in his intellectual development, one is amazed at the extremely favorable social advancement that the child exhibits at this time. On the basis of today's examination, this examiner is somewhat skeptical of Morris' ability to progress with average first grade work, despite the seeming recommendation of his teacher, but the examiner is willing to concede this point if the school is willing to work with the boy and not

put too much stress and pressure for learning achievement during his first year in grade school. Considering the social growth that has taken place in this boy, one is tempted to state that his present environment must be an accepting and rewarding one for him to make such social progress."

Psychiatric examination of Morris revealed: "He was friendly and easily responsive. He spoke easily. He seemed to know what he was saying and, indeed, asked if he might not stay with the rest of his siblings. He said, somewhat pathetically, that he would "like to stay with them and nobody wants to give me a chance." It is our feeling that this youngster ought to be given an opportunity to develop a little more fully and that he might be retested in a year. In the meantime, we feel that he should continue in the same foster home in which he now finds himself."

The third child, Peter, born in April of 1955 was seen for psychological examination on June 12, 1959 at which time the subject was 4-2 years of age.
The psychologist stated: "The subject appeared to be fairly friendly, could follow some simple directions and illustrated some appreciation of his circumstances and behavior. Several psychological tests were attempted but due to the lack of speech, hyperdistractibility and general hyperkinesis, most of these could not be completed. On the basis of this limited observation and testing, his approximate mental age appears to be 2-1 years which would be equated to an I.Q. of 52. However this must be taken in the light of a possible organic concomitance as well as extreme emotional and physical deprivation in his early development. Since Peter has been in a foster home for such a short time, it seems as if he is making extremely rapid gains in terms of socialization and development; it would be unfair at this time to simply attribute his behavior to "incurable mental deficiency." Under the influences of a protective, loving, accepting home environment, this child may begin to expand in personality and possible mental development. However, neurological study should not be overlooked as well as possible endocrinological consultation should be sought. Further examination is indicated in the near future."

Peter was re-examined by the same psychologist on April 6, 1960 at which time he was just 4 years of age. The psychologist reports: "On today's testing session, Peter obtained a mental age 2-11 years and an I.Q. of 58. Today's session disclosed a rather cheerful and happy young boy who was fairly cooperative although had an extremely short attention span and was somewhat hyperactive during the testing and interview session. He was able to give description of several toys that he had and could use such words as Santa Claus, snowman, phone and dog. It is to be noted that at last examination, the subject could hardly walk or talk and exhibited a rather retarded demeanor and mentation. Although the patient is still functioning in the mentally retarded category, there have been some significant changes in social, adaptive areas. It is still this examiner's impression that we are dealing with a subtle organic process in operation as well as extremely early emotional and physical deprivation. At the present time it would seem unwarranted to remove Peter from his present foster home but would suggest another year's observation at this home, at the conclusion of which he would be re-examined."

Psychiatric examination of Peter revealed: "We feel that this youngster has made a considerable amount of social progress. Note that he is becoming toilet trained and that though still restless he can pay attention to some things and, in general, is showing evidence of growth. With this in mind, then, we would recommend that he be placed in a kindergarten where he could learn to socialize further and that he continue in his present foster home for at least another year."

The fourth child, Wilbur, born in August of 1956, was 2-10 years of age when he was examined on June 12, 1959. The psychologist reports: "A rather chubby and friendly youngster who was carried into the examination room by the examiner. Wilbur can walk by holding onto objects or by someone holding his hand. He does not talk but is able to make some sounds. He continues to drool, crawls a great deal and definitely appears to be retarded in his development. On the Gessell Developmental Schedules, Wilbur showed general retardation in language development and was only able to achieve a 15 month level in the other performance areas. Thus, at the present time, the child is functioning far below his chronological age. The developmental quotient at this time would approximate a score of 50. Wilbur appears to be trying to adjust to his environment and is certainly very responsive to those who give attention to him. He was seen in the playroom where he was given a cup of milk which he proceeded to lap up as an animal would. Thus, it seems that this early deprived youngster has not been given the type of environment which would help him to learn to adjust and to develop along those lines of other children within his age group. Consequently, it is felt that this youngster would certainly profit, and possibly show an increase in his development, in a more structured, warm and accepting environment."

Wilbur was seen again by the same examiner on February 1, 1960 at which time he was 3-6 years of age. At this examination, the psychologist reported: "Wilbur appears to have made a good improvement during the past six months. He is now able to take a few steps independently, able to manipulate objects and understand simple instructions. He says a few words and the foster mother indicates that the youngster says "mommy" and recognizes his peers. Although his ability to walk is improving, it is still rather difficult for him to stand for any protracted period or walk a long distance. There also appears to be some difficulty in grasping small objects with the patient experiencing some difficulty in the use of his thumb. On the Binet Scales, it appears as if Wilbur has reached the two year level of development. The obtained Intelligence Quotient of 60 represents an approximate increase in the I.Q. score over his previous examination, although still showing some signs of retardation in the motor and language area. Nevertheless he appears to be responding to his environment. In view of the fact that he has shown good improvement over the past few months, it is recommended that he remain in the present foster home and be reevaluated within the next six months."

Wilbur was re-examined on July 21, 1961, almost five years of age. At this examination another psychologist reports: "That there was some drop in the Intelligence Quotient from the previously reported. At the present examination, Wilbur appears to have difficulty in speech and can only say occasional, isolated words. He was unable to draw any vertical or horizontal lines with a pencil and made mere scribbling. It is reported that he is not toilet trained and in general he appears somewhat clumsy and uncoordinated suggesting evidence of organicity. He is now able to walk however and this examiner seems to feel that the Hospital for the Mentally Retarded is indicated."

Psychiatric examination of Wilbur reports: "Looks considerably better physically and shows evidence of maturation. However, he is still definitely limited intellectually. The possibility of kindergarten at this time might be considered but certainly he is not completely ready for this kind of program. Eventual placement at the Hospital for the Mentally Retarded may be indicated if further intellectual growth is not forthcoming."

The fifth child, Anthony, was born in October of 1957 and when examined on June 12, 1959 was 1½ years of age. The

psychologist reports: "Anthony is much more alert and intelligent looking than his four siblings who came simultaneously with him for examination. He smiled readily and is rather nice looking. A certain weakness or muscular under-development was noted in his hands although he knew how to manipulate things that many infants 18 months of age can do. Anthony was found to have an I.Q. of 89 which is in the dull-normal category. However, it was noted that there was a complete avoidance of any speech and he could not even repeat the sound "dada." Also, midway through the testing program, he showed fatigue which might have taken a toll on his intellectual efficiency."

The psychiatrist reports: "Anthony seems to be a normal child and we felt that he should continue in his present foster home." It is interesting to note that during July, 1961, parental rights were terminated by the court and that Anthony stands a good chance of being adopted in the very near future.

The last of the Smith children, Loretta born in May of 1959 was not seen at the Mental Hygiene Clinic because of previous psychological examination through outside sources. This examination reports that Loretta is currently functioning within the dull-normal to normal category and appears to be fairly good adoption-placement material.

#### Parents Immature Individuals

The children's parents were both born in Delaware. The mother, Mrs. Anne Smith, a 29 year old, white, American, was referred to the Mental Hygiene Clinic for the following reason: "Mrs. Smith was unable to care for her children and her home. Based on numerous complaints of neglect, the Family Court ordered their removal and placement in foster homes. Your evaluation and recommendation will help us in determining how much responsibility Mrs. Smith can assume for her children." Mrs. Smith completed the 8th grade and was married at the age of 20. Information regarding birth and early development was not available. Her attitude towards the children and home reflected her low standards of cleanliness and supervision. Objective reports from the investigating agencies stated that the home "was filthy and infected with vermin." Mrs. Smith was seen as "an extremely poor housekeeper." A good relationship between husband and wife was felt to exist.

At the time Mrs. Smith was seen for psychological examination, she was employed. She expressed concern over her children's removal from the home and contended that plans were being made for their return. Intellectually, she was found to be functioning on a mentally retarded level mild with an I.Q. of 74. There was very little intertest scatter which would suggest a higher potential.

Personality tests revealed an immature, dependent individual who is prone to be rather self-centered, cold and barren in her interpersonal relationships. Immature, puerile responses tended to dominate in her record, reflecting her weakness and inadequacy in dealing with complex socio-cultural facets of her environment. Her judgement appeared to be limited and unrealistic. The ego structure was weak and it was doubtful if she could provide more than a marginal environment for her children without supervision.

The psychiatrist reported: "In the psychiatrict interview, it was noted that though the patient went into the 8th grade in school she herself stated that she was "kind of slow in all grades." She stated that she failed the 3rd and 4th grades. There was no gross evidence of physical or neurological disturbance of a contributory nature.

Something can be learned about the patient's personality when it is noted that she came to a rather important interview one-half hour late. Her attitude of "missing the early bus" and her lack of concern or embarrassment points up her childishness and her naivete. She seemed to have no

idea as to why she was here except that it had something to do with "being tested;" she had no concept as to why the children were taken away from her nor for that matter as to why the Department of Public Welfare had been active in her case. To a direct question, she responded "I suppose they were supposed to." Regarding her children, she stated that she had spoken to the "woman" and she would like to have her baby with her but seemed to be unable to think very much beyond this point. However, to the direct question as to what about the rest of the children, she stated that she is now employed, working to get her bills paid and one presumes that she meant that she was taking the rest of her children back after her bills had been paid. It is obvious that this woman will need assistance and supervision indefinitely if she is to give her children any kind of life."

The father, a 30 year old, white, American, was seen concomitant with his wife's referral. Mr. Smith was one of 9 children born during the depression. His father was described as "a heavy drinker and an unemployed person because of having tuberculosis." The children were removed from the family by court order. Five were sent to "Stockley." The mother was "not considered a very stable person." Mr. Smith was described as a "quiet, obedient child with a serious disposition." The school report indicated "that he tries but apparently he is not a good student." His ratings are mostly C's and D's. Psychological tests at the age of 8-2, indicated that he had "an average native intelligence" but retardation in language development, especially reading is apparent.

The father completed the 8th grade. He was in the army for two years and at the time of examination in August of 1959, had been employed as a laborer. Although he has "always worked steadily, he never earned a high income." The father expressed superficial concern over his children when seen for psychological examination. Although he admitted that the home which he had provided was not completely adequate, he felt that it was the best he could provide. He, too, appeared concerned about his children and claimed to be making plans for their return.

Intellectually, he is functioning on an average level of intelligence with an I.Q. of 109. The intertest scatter was suggestive of uneven emotional functioning. The personality tests revealed a rather self centered, immature individual who tends to be apathetic, lacking in drive and unable to assert himself in many situations. He showed some tendency to withdraw from close interpersonal contacts and to seek gratification through immature fantasy. This rather dependent patient exhibited shallow affect and questionable judgment. It was felt that he was not likely to take more than cursory interest in his children."

The psychiatrist reports: "We saw no gross evidence of physical or neurological disturbance with Mr. Richard Smith, Sr. In the psychiatric interview he was generally passive and cooperative but one suspects some hositlity under the surface which he could not express ordinarily. As noted above he came to the meeting one half hour late and it is, of course, impossible to determine who was responsible for the delay. He did not show any great amount of anxiety regarding this."

In summarizing his interview with Mr. and Mrs. Smith, the psychiatrist reported: "It is quite obvious that we are dealing here with two very immature individuals and it will be difficult to make a disposition in their case. Indeed, we feel that a conference between representatives of all agencies involved as well as ourselves, to discuss plans for this case might be worthwhile."

A conference was held with workers of various social agencies, State Department of Welfare and the Mental Hygiene Clinic's Staff in August of 1960. As a result of this conference it was agreed that one of the children, Richard, would be hospitalized

at the Hospital for the Mentally Retarded; that Wilbur and Peter, who are definitely retarded, be re-examined in six months to one year with the prospect that they will also require hospitalization. This delay will give them sufficient time to see what can be accomplished with them in foster home placement. Anthony and Morris are to stay in foster homes and be re-evaluated at such time that the parents show some ability to move emotionally and are able to take care of them."

The psychological study of this particular family seems to indicate that the father sustained a very emotionally deprived early environment. Despite a measured I.Q. in the average, normal range, it appears obvious that he is not functioning up to this level on a practical, everyday, basis. It is hypothesized that the mother's background was quite similar to her husband's and she, too, exhibits emotional immaturity with a rather passive-dependent personality structure highlighted also by moderate mental retardation (I.Q. 74) and a kind of schizoid adjustment to the world.

**The Role Of The Physician**

What are the implications and conclusions that can be drawn from this family portrait? Theoretically, the role of the family physician in dealing with the mentally retarded, should be the same one that he displays with all other patients. Mental capacity, although of much concern to the psychologist, educator, social worker or the patient's family, nevertheless, in practice, requires the physician to become grossly involved when the parents take their child for diagnosis, reassurance and "cure." Many times the physician is the first authority to react to the patient's condition in terms of assessment of the effects of brain damage high fevers, accidents and traumatic emotional experiences. The family's experience with the physician, his ability to explain the results of the diagnosis is most important in terms of establishing the basic attitudes of the family towards the retarded member. The physician should be frank without instilling feelings of hopelessness, despair and rejection of the patient and at the same time avoid raising unwarranted assurances of curing one who in all probability cannot be "cured" in terms of group, normal, functioning. The visit to the family physician with the admission that something is wrong with a child( is made very often by a parent only after a long period of painful indecision has taken place. It would be very trying to expect any method of presenting a diagnosis of mental retardation to parents that would avoid unhappiness. What should be avoided is the communication of the idea that the mentally retarded person is hopeless and really "incurable." A program of medical, educational and psychological service as well as orientation and education of the family may provide satisfaction to the patient and provide him with rewarding and enriching life experiences.

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## CURRICULUM FOR DELAWARE TWO-WAY RADIO MEDICAL CONFERENCE

DECEMBER, 1961 SCHEDULE

TOPIC AND FACULTY

**December 5** Office Recognition of Anemia," Edward H. McGehee, M.D., Hematologist, Pennsylvania Hospital

**December 12** "Gallbladder—Fact and Ficton," Rodman Finkbiner, M.D., Assistant Physician, Pennsylvania Hospital

**December 19** "Urinary Infection in Children," Alexander Michie, M.D., Assistant Professor in Pediatric Surgery, University of Pennsylvania

# Editorials

## MENTAL HYGIENE CLINICS

Elsewhere in this issue the State Psychiatrist presents an historical survey of the organization of Mental Hygiene Clinics in the State of Delaware. We have come so far since the beginning of this project in 1927 that we frequently take things for granted.

The Mental Hygiene Clinics as well as the other psychiatric services in the State of Delaware are known throughout the medical world. The job has been a tremendous one and the results will stand as a living monument to our State Psychiatrist.

## HEART MURMURS

Much of our knowledge regarding the diagnosis of heart disease and the prognosis of many cardiac conditions is based upon the type of murmur heard. Despite the recent scientific advances in instrumentation, accurate observation and description of cardiac murmurs remains a most important part of any physical examination.

Approximately three decades ago Dr. Samuel A. Levine, pioneer heart specialist at the Peter Bent Brigham Hospital devised a system of grading the intensity of cardiac murmurs on a numerical basis. To the House Staff of the Brigham and other physicians who were fortunate enough to come under the guidance of Dr. Levine, this system was an excellent method of not only making a record of ones findings but also of training ones self in the art of auscultation.

Unfortunately, in the ensuing years many physicians with insufficient training and with no desire for furthering their knowledge have adopted a numerical system of grading murmurs based apparently upon their imagination. Notations are commonly seen to the effect of a grade one harsh murmur transmitted in such and such a direction. Such a murmur by definition could not be grade one.

Other physicians, well meaning but misinformed, attempt to edit their findings. Hearing a grade two or grade three murmur but believing it to be benign, they will call it a grade one murmur knowing that Dr. Levine considers all murmurs grade two or greater as being significant until proven otherwise.

Fortunately, clarification in this area of confusion has come from the man who originally devised this system. In the July 29, 1961 issue of the JAMA, Dr. Levine briefly reiterated his criteria for rating murmurs on a basis of one to six. His statement is contained on a single page and is so concise, definite, and authoritative that it would be ill-advised to attempt to further condense this communication. All physicians who at any time in their practice resort to the use of a stethoscope should read this latest comunication.

## CAROTID ANGIOGRAMS

This procedure has come into wide clinical use during the past decade. Any new procedure of this type must be critically evaluated from two viewpoints; how much information is rendered by the use of this procedure and what are the risks? Does the information obtained justify the risk?

In the October 7th issue of JAMA, Rowe and Arditti report on a series of five hundred and forty carotid angiograms carried out on four hundred and fifty-six patients in a period of three years. The accuracy of the procedure was well over ninety-five precent. The complications were two percent and there was only one death attributable to the procedure. Considering the severity of the diseases being studied, this is indeed an excellent record and demonstrates clearly not only the effectivenes of this procedure but its definite safety.



# President's Page

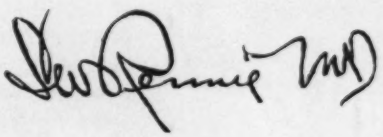
An article in the "Medical Economics" by Dr. Ingegno suggested my writing the following:

At the last meeting of the House of Delegates of the Medical Society of Delaware, a resolution was passed to recognize the suggestions of the Delaware State Nurses Association regarding the mininum standards of employment for office nurses. These should not be a problem for the physician.

It is necessary to cooperate with the nurses, because they are our chief ally, in spite of the stand which the American Nurses Association makes on the King Anderson Bill for putting the aged's hospital care under Social Security. Having talked to many hospital nurses I find that they do not even know what this bill is! I believe that the officials of the A.N.A. are not representative of the working nurse.

This, however, is not meant to censor the A.N.A., but to gather us, the physicians and the nurses, more closely together as a unit, to support local actions, and to foster more unity and respect between these two great professions. This could serve to interest a larger number of students in the nursing profession, which is greatly needed.

Let us make the nursing profession a greater one in education, respect, and also economically. As Dr. Alfred P. Ingegno, in a recent article in Medical Economics says, "Only if we are their allies, have we the right to expect that they will be ours."



# In Brief

**The Life Span**

The average remaining length of life after 65 has barely increased during the past 60 years and will not until it becomes possible to postpone the aging and degenerative changes that occur in man as his chronological age advances. Although saving lives of children and young adults has made it possible for more people to live to the ages of 65, 75 and 85 years or older, individuals now reaching 65 do not have a much greater life expectancy than those of the same age had in 1900, according to C. C. Dauer, M.D., Medical Advisor, P.H.S.

**Belated Visitor**

An upswing in the influenza cycle, likely to hit during this fall and winter, has been reported by the U.S.P.H.S. which recommends immediate vaccinations for persons in the groups accounting for most of the previous deaths: persons with heart disease; pulmonary disease; diabetes and other chronic illnesses; persons over 65 and pregnant women.

**Diplomats, M.D.**

Physicians to volunteer service in the mission field on a temporary basis are being sought by the Department of International Health in cooperation with the AMA. Application forms which will be used by the agencies to consider the qualifications of the applicants may be obtained by writing to: AMA, Department of International Health, 535 North Dearborn Street, Chicago 10, Illinois.

**Auditory Screening Techique**

A film to stimulate interest in an auditory screening technique for infants is being released by Johns Hopkins University. It sets forth an effective procedure for early detection of hearing impairments and possible abnormalities in motor coordination and mental capacity. Training institutes at Johns Hopkins will teach physicians, nurses and other professional personnel in speech and hearing.

**Reprints**

Reprints of a clinical pathological conference at the NIH on *Differential Diagnosis of Mitral Regurgitation in Childhood* are now available to interested physicians upon request.

**A Welcome Depression**

Paralytic polio will slump to an all-time record low this year if the present trend continues. Figures of U.S.P.H.S. indicate a continuing drop in Type I Polio as a predominant cause of crippling. Provisional figures show that so far this year more than 50% of the paralytic polio was caused by Type III Virus—a type not susceptible to the presently licensed Sabin strain. The P.H.S. action approved production of only one of the three Sabin vaccine strains—the one designed to combat Type I Virus. Licensing of Types II and III strains are still to come.

**Personal Glimpses**

Drs. Gerald A. Beatty, Maynard H. Mires and Robert L. Dickey have been appointed to Delaware's Board of Post-Mortem Medical Examiners . . . O. N. Stern, M.D., gave an illustrated talk on the activities of the Delaware Cancer Society to the Wilmington New Century Club, Junior Section . . . Robert W. Frelick, M.D., showed the film "The Other World" at a meeting of the Auxiliary to the V.F.W. Post, followed by a question period . . . William T. Reardon, M.D., spoke on "Hypnotism and Medicine" at a meeting of the Wilmington Lions Club . . . Drs. Mark Cohen, Marvin Dorph and Edward M. Bohan were a committee of three conducting the Diabetes Detection Drive in Wilmington . . . Mrs. Marie Prickett received an award for the humanitarian service of her late husband, Clarence J. Prickett, M.D., awarded posthumously by the Delaware Cancer Society . . . Leslie W. Whitney, M.D., was reelected president of the Delaware Cancer Society; Joseph A. Arminio, M.D., was reelected vice-president and Drs. Robert Frelick, Lemuel C. McGee and S. Thomas Miller were appointed as members of the Board of Directors . . . Raymond A. Lynch, M.D., addressed the Delaware Safety Council's fleet safety section on modern medicine as it affects driving . . . Davis G. Durham, M.D., gave an illustrated talk on "Project Hope" at the Hillcrest Memorial Methodist Church . . .

**Cancer Progress**

A $17,800 grant has been given to the Bio-Chemical Research Foundation, Newark, to help in its search for a weapon against cancer. The Delaware Division of the American Cancer Society will supplement funds available from the national group to help finance the Foundation's work. The premise of their search is that the body contains the mechanism to overcome cancer.

An anti-cancer vaccine, which has been used to treat and prevent cancer and leukemia in animals, may lead to success in fighting cancer in humans. Antibodies for this would be grown in horses. Doctor D. E. Carvalho, Director of Cancer Research with Rand Development Corporation, Cleveland, reported that the production and use of such a vaccine would take about a year.

**Coincidental?**

The District of Columbia has the highest number of hospital beds per 1000 population at 17.8, according to *Patterns of Disease* . . . D.C. is followed by New York with 14.0 and Massachusetts with 13.2.

**The Sunny South**

The best advice for avoiding acute health conditions would be to "head for the sunny south." The Health Insurance Institute reported that people living in the South average fewer acute illnesses than residents of any other region while the average person living in the West not only leads in such conditions but suffers more restricted activity and bed confinement as a result.

**Research Grants**

The American Thoracic Society is receiving applications for research grants in the field of respiratory diseases, including tuberculosis, for the year beginning July 1, 1962. Applications must be received not later than December 15, 1961. Write: the Division of Statistics, American Thoracic Society, 1790 Broadway, New York 19.

# Delaware Academy of General Practice

## SCHEDULE OF EVENTS

### FRIDAY, DECEMBER 1, 1961

9:00 P.M. ANNUAL BUSINESS MEETING—*Academy of Medicine, Lovering Avenue at Union*

Refreshments following meeting

### SATURDAY, DECEMBER 2, 1961

Tenth Annual Scientific Assembly of Delaware Chapter, A.A.G.P.

A.M.

9:00 - 9:30 REGISTRATION—VISIT EXHIBITS

MODERATOR, MORNING SESSION: William D. Shellenberger, M.D.

9:30 PRESIDENT'S WELCOME: Joseph Davolos, M.D.

9:30 - 10:30 THE SCOPE OF INDUSTRIAL MEDICINE VERSUS GENERAL PRACTICE—C. Anthony D'Alonzo, M.D., *Assistant Medical Director, E. I. duPont de Nemours and Company, Wilmington*

DISCUSSION: William A. Wright, M.D.
M. B. Pennington, M.D.

10:30 - 11:00 RECESS—EXHIBITS

11:00 - 12:00 MUST PATIENTS BE DENIED ALL PLEASURES?

Chauncey Leake, Ph.D., L.H.D., *Professor of Pharmacology, Ohio State University College of Medicine. President, Society for Experimental Biology and Medicine. Past-President, American Association for Advancement of Science*

DISCUSSION: Allston J. Morris. M.D.
Alfred E. Bacon. Jr.. M.D.

P.M.

12:00 - 1:45 LUNCHEON—EXHIBITS

MODERATOR, AFTERNOON SESSION: Rhoslyn Bishoff, M.D.

1:45 - 2:45 GROWTH FAILURE IN INFANCY

Stuart S. Stevenson, M.D., *Professor and Chairman, Department of Pediatrics, Seton Hall College of Medicine and Dentistry*

Mead Johnson Distinguished Lecturer Program

DISCUSSION: David A. Levitsky, M.D.
Herman Rosenblum, M.D.

2:45 - 3:15 RECESS—EXHIBITS

3:15 - 4:15 RECTAL RECONNAISSANCE

Howard Trimpi, M.D., F.A.C.S., *Specialty, Diseases of Colon and Rectum, Allentown, Pennsylvania*

DISCUSSION: Joseph Arminio, M.D.
Caleb Smith, M.D.

4:15 ADJOURNMENT

6:30 COCKTAILS—*Hotel duPont—Gold Ballroom Foyer*

7:30 DINNER, ENTERTAINMENT, DANCING — *Hotel duPont, Gold Ballroom, by reservation*

9:00 DANCE MUSIC by Joel Scott Orchestra

# LETTERS TO THE
# Medical Society of Delaware

New York Medical College
Flower & Fifth Ave. Hospital

Dear Doctors,

I want to very sincerely thank the Scholarship Committee for having awarded me the Medical Society of Delaware Scholarship and very especially the practicing physicians of Delaware who have contributed so generously toward making this scholarship a reality.

Several years ago, I reluctantly initiated my pre-medical program only because my desire to study medicine was greater than my fear of being thwarted because of financial reasons. Because of your generosity, I thank God, today, for aiding me in making the right decision at that time.

I promise you that I will work very hard and diligently here in Medical School so that I might some day, with the help of God, be allowed to enter society and practice medicine with the prime purpose of administering to the sick.

Many thanks, again, my dear friends.

Very sincerely,
Alfonso Paul Carlo
Class of 1965

210 S.E. Front Street
Milford, Delaware

Gentlemen:

Within the next few days I will begin my medical training. I know that the road to becoming a physician will not be easy. There certainly will be obstacles in my path. One obstacle has been greatly lessened through the generosity of your organization. By awarding me a Medical Society Scholarship, the financial burden placed on my parents has been greatly decreased. At this time I would like to express on behalf of myself and my parents our extreme gratitude to The Medical Society of Delaware for this award.

Very sincerely yours,
Robert B. Brereton

# Auxiliary Affairs



Mrs. Joseph V. Casella

## Profile Of Our President

Our president, Mrs. Joseph V. Casella, has been active in Auxiliary affairs for many years. She has worked on the Ways and Means Committee, and has been Chairman of the Revisions and Today's Health Committee for New Castle County Auxiliary. She has also served as Recording Secretary, Bulletin, Safety, and Revisions Chairmen for the State Auxiliary

Mrs. Casella, who was born Betty Tallentire in Scottsdale, Pennsylvania, decided on nursing as her profession. She took her training at Sibley Memorial Hospital in Washington, D.C. After graduation she worked as supervisor of a nursery at Sibley.

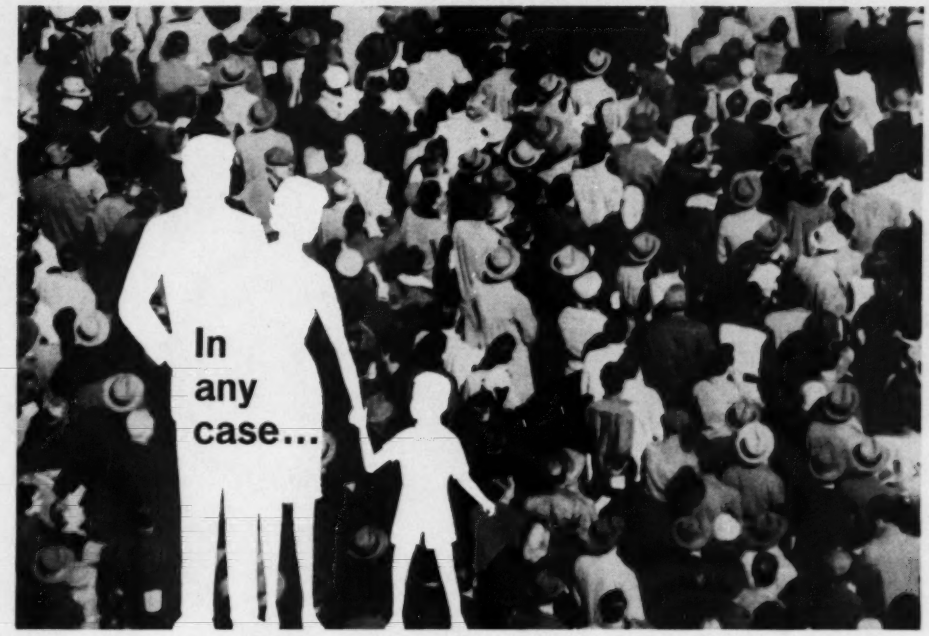
She married Dr. Casella after he had finished his residency and had gone into the Army at Fort Sam Houston. While he was overseas, she returned to Sibley, where she was floor supervisor on obstetrics. The Casellas moved to Wilmington 13 years ago.

The Casellas have one daughter, Pamela (Pam), who is a junior at Alexis I. DuPont High School. She recently was one of four students chosen from Alexis I. to participate in a Science Symposium at the University of Delaware. She was also Delaware State Novice Diving Champion in 1957 and Delaware State Women's Champion in 1959. She is a member of the Vesper Swim Club of Philadelphia.

Mrs. Casella's nursing training has influenced her interests outside the Medical Auxiliary. She is a member of the Junior Board of Wilmington General Hospital and enjoys working in all phases of their program. She has also worked with the Red Cross on their chest x-rays and blood bank programs. For five years she was a homeroom mother for Pam's rooms and was chairman of the homeroom mothers when Pam was in 6th grade.

Her main hobby is gardening. She is an enthusiastic rose grower, and has taken several courses at the YWCA on gardening and landscaping. She recently decided to take up golf and enjoys it very much. To help her keep up with all her reading, she took the Reading Dynamics Course this year, and recommends it highly.

This year the Auxiliary plans to emphasize programming, legislation, public relations and community service. Delaware Health Fair will provide an excellent field for public relations for the Auxiliary. Mrs. Casella hopes to interest more members to take an active part in Auxiliary affairs.




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* lowers motility
* **controls diarrhea**

*Lomotil* brings prompt symptomatic control in diarrhea, either acute or chronic.

Both pharmacologic and clinical evidence indicate that Lomotil selectively lowers the propulsive component of gastrointestinal motility without relaxing intestinal sphincters. So efficient is this action that studies in mice have shown Lomotil to be effectively antidiarrheal in one-eleventh the dosage of morphine.

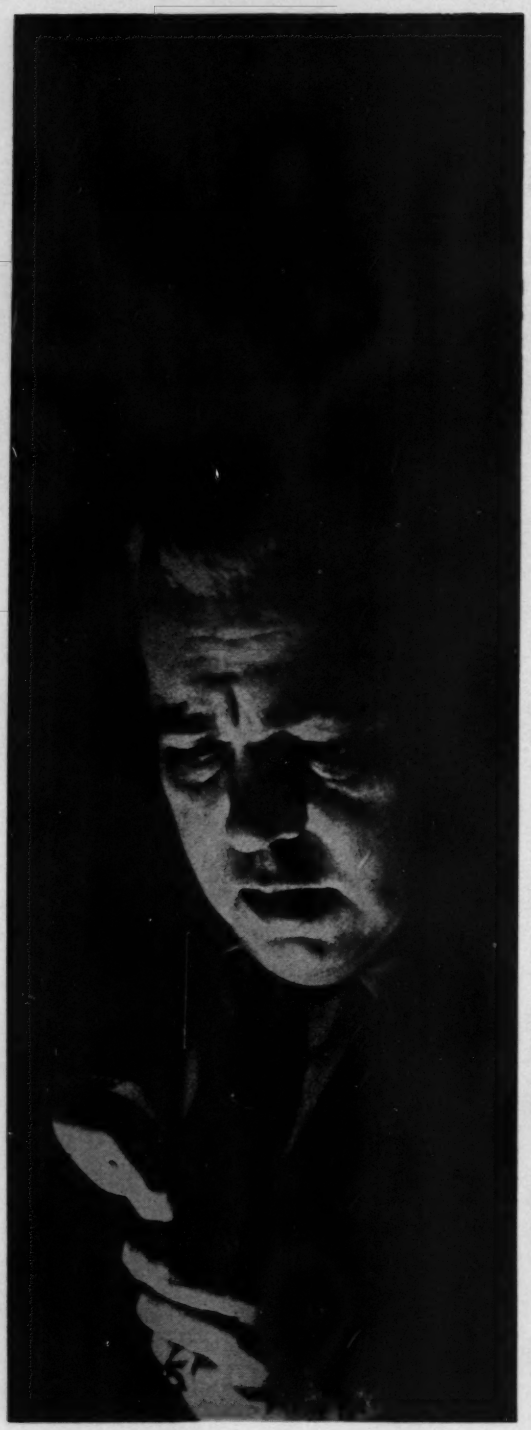
Such striking antidiarrheal activity strongly suggests that Lomotil is the drug of *first* choice for prompt and positive control of diarrhea.

**Dosage:** The recommended initial dosage for adults is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. of atropine sulfate to discourage deliberate overdosage. Recommended dosage schedules should not be exceeded.

*An exempt preparation under Federal Narcotic Law.*

Descriptive literature and directions for use available in Physicians' Product Brochure No. 81 from G. D. Searle & Co., P.O. Box 5110, Chicago 80, Illinois.

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# Day and night– less wheezing, coughing, labored respiration in chronic bronchitis and emphysema

New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

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| Isuprel® (brand of isoproterenol) HCl | 2.5 mg. |
| Ephedrine sulfate | 12 mg. |
| Theophylline | 45 mg. |
| Potassium iodide | 150 mg. |
| Luminal® (brand of phenobarbital) | 6 mg. |
| Alcohol | 19% |

*Adult Dose:* 2 tablespoons 3 or 4 times daily.

*How Supplied:* Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

# New ISUPREL® compound ELIXIR

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| Vitamin A | 25,000 U.S.P. Units |
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| Vitamin C | 200 mg. |
| Pyridoxine Hydrochloride | 5 mg. |
| Calcium Pantothenate | 20 mg. |
| Vitamin $B_{12}$ | 5 mcg. |

SQUIBB *Squibb Quality—the Priceless Ingredient*

'Theragran'® is a Squibb trademark

# "nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

**cardiac diseases** "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

**arthritis** "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

**digestive diseases** Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

**degenerative diseases** "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264

**infectious diseases** Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

**diabetes** Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan, G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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# in bacterial otitis media Panalba* promptly to gain precious therapeutic hours

In the presence of bacterial infection, taking a culture to determine bacterial identity and sensitivity is desirable—but not always practical.

A rational clinical alternative is to launch therapy at once with Panalba, the antibiotic that provides the best odds for success.

Panalba is effective (in vitro) against 30 common pathogens, including the ubiquitous staph. Use of Panalba *from the outset* (even pending laboratory results) can gain precious hours of effective antibiotic treatment.

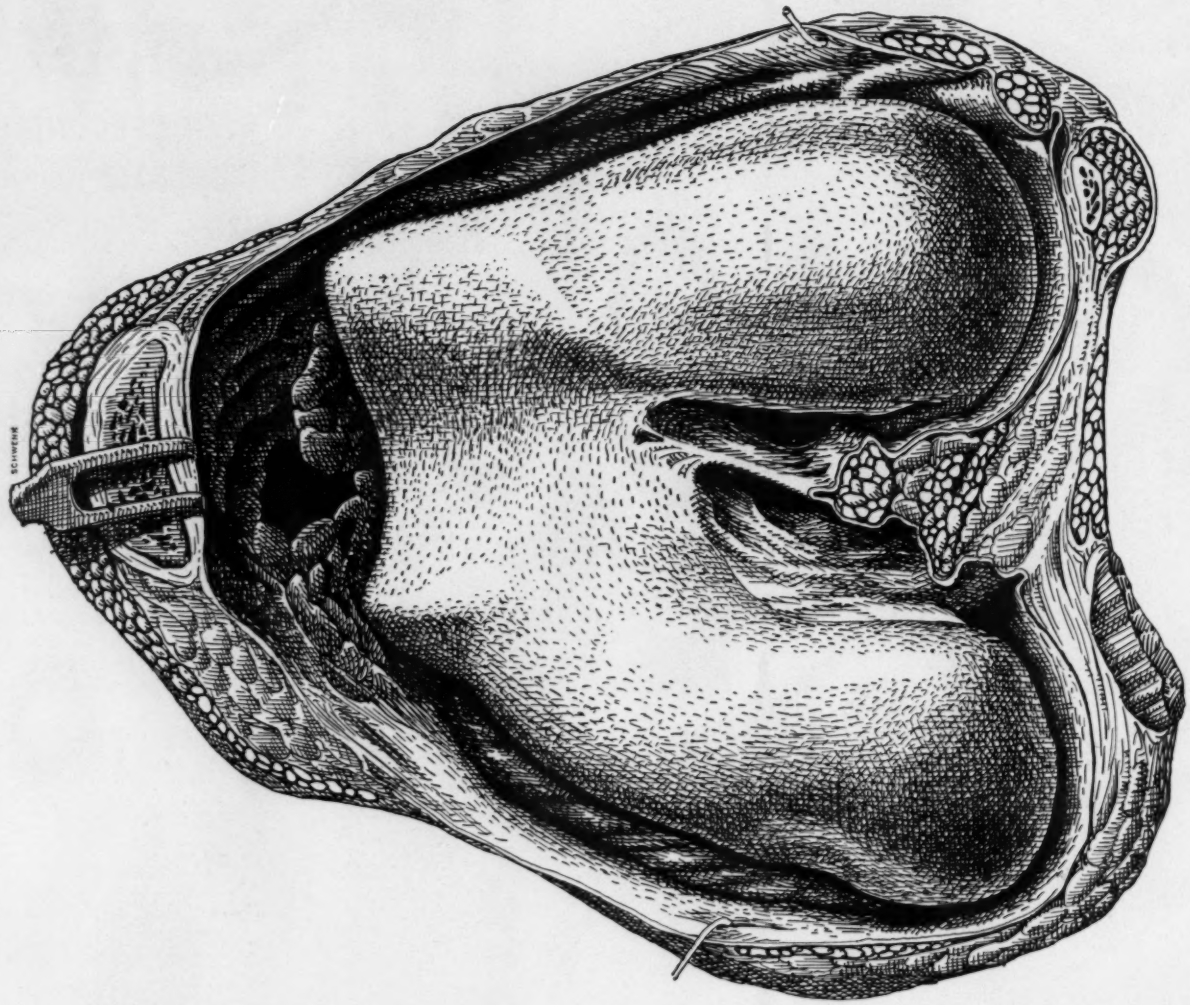
SUPPLIED: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.
USUAL ADULT DOSAGE: 1 or 2 capsules 3 or 4 times a day.
SIDE EFFECTS: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
Urticaria and maculopapular dermatitis, and a few cases of leukopenia have been reported in patients treated with Albamycin. These side effects usually disappear upon discontinuance of the drug.
CAUTION: Since the use of any antibiotic may result in overgrowth of nonsusceptible organisms, constant observation of the patient is essential. If new infections appear during therapy, appropriate measures should be taken. Total and differential blood counts should be made routinely during prolonged administration of Albamycin. The possibility of liver damage should be considered if a yellow pigment, a metabolic by-product of Albamycin, appears in the plasma. Panalba should be discontinued if allergic reactions that are not readily controlled by antihistaminic agents develop.
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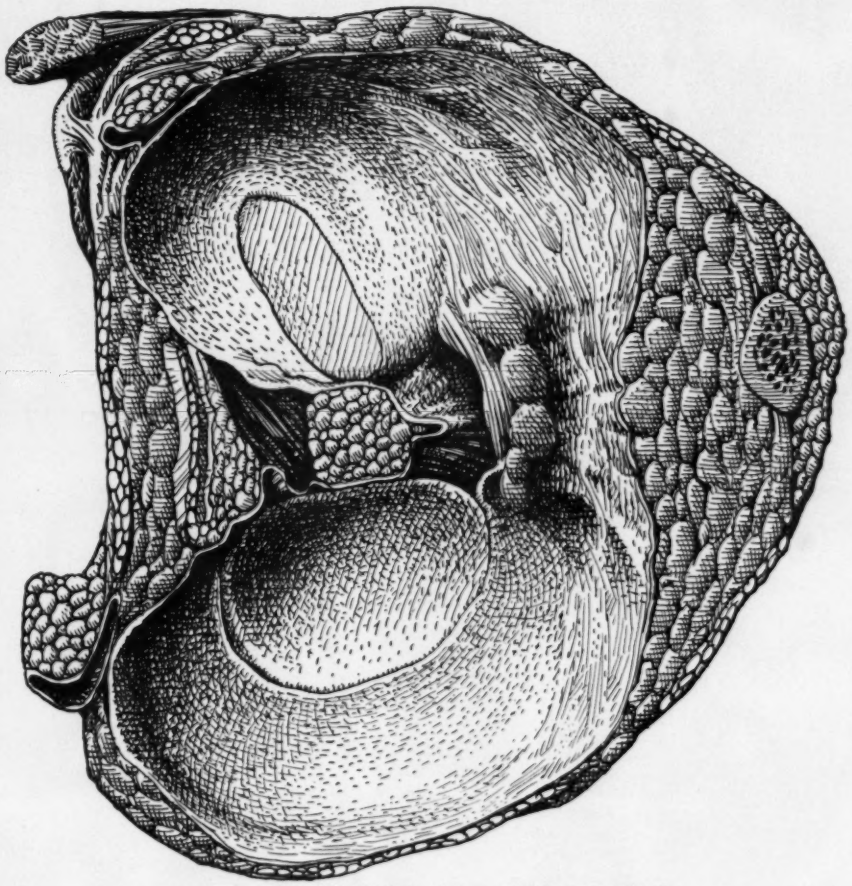
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*Outstanding for Short- and Long-term Therapy*

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(Knee Joint. Left: distal end of femur; Right: proximal end of tibia)

**ARISTOCORT** is an outstanding "special purpose" steroid when the complicating problem is increased appetite and weight gain, sodium retention and edema, cardiac disease, hypertension or emotional disturbance and insomnia.

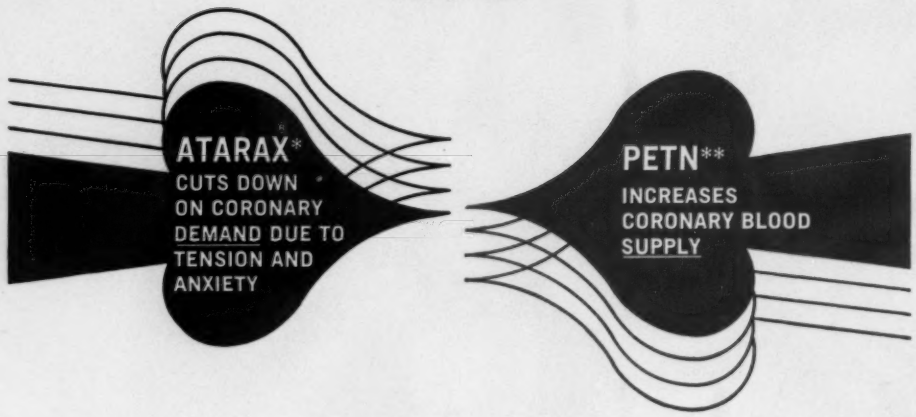
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Supplied in bottles of 100. Prescription only.

1. Clark, T. E., and Jochem, G. G.: Angiology **11**:361 (Aug.) 1960.

*brand of hydroxyzine **pentaerythritol tetranitrate

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These findings confirm the continuing vitality and broad-spectrum dependability of Terramycin, as reported through more than a decade of extensive clinical use.



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The dependability of Terramycin in daily practice is based on its broad range of antimicrobial effectiveness, excellent toleration, and low order of toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions are rare. Aluminum hydroxide gel may decrease antibiotic absorption and is contraindicated.

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*Jacques, A. A., and Fuchs, V. H.: J. Louisiana M. Soc. 113:200, May, 1961.

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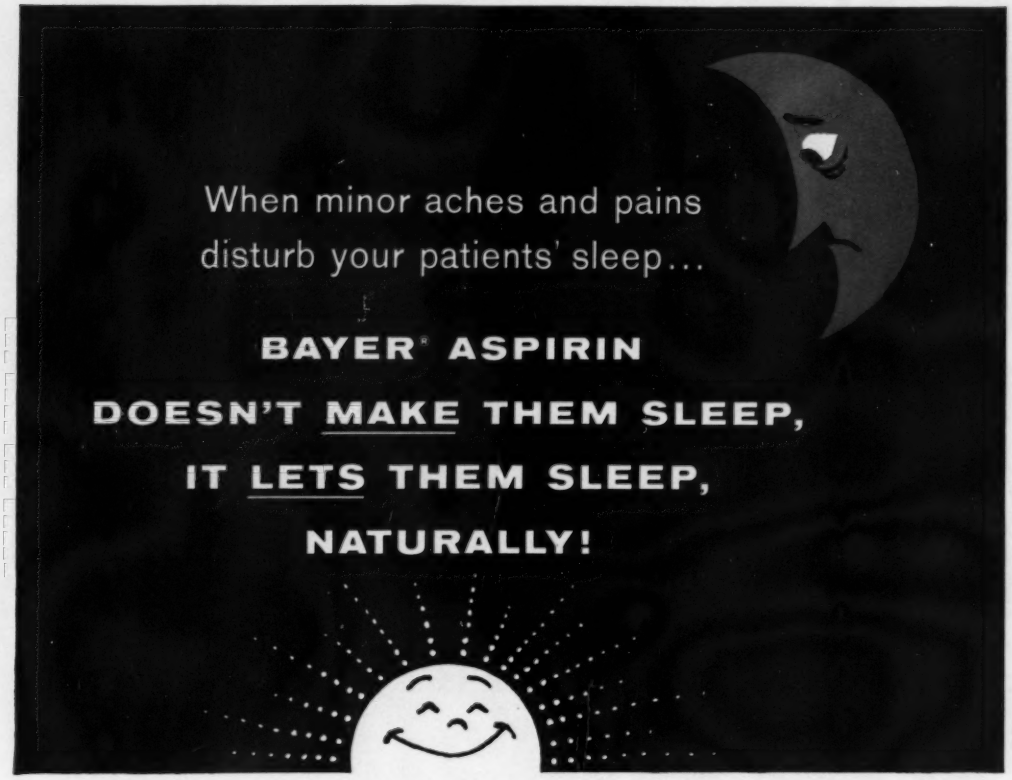
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535 N. Dearborn St., Chicago 10, Ill.

# Tareyton delivers the flavor...




## Here's one filter cigarette that's really different!

The difference is this: Tareyton's Dual Filter gives you a unique *inner* filter of ACTIVATED CHARCOAL, definitely proved to make the taste of a cigarette mild and smooth. It works together with a pure white *outer* filter—to balance the flavor elements in the smoke.

***Tareyton delivers—and you enjoy—the best taste of the best tobaccos.***




DUAL FILTER Tareyton

Product of The American Tobacco Company — "Tobacco is our middle name" © A. T. Co.



# Why Homer Jackson's work is important to you...

Talking on the radio-telephone is Homer "Bud" Jackson, both a scientist and a hard-working buyer for a company processing Florida oranges into frozen juice concentrate.

He has just made a decision that's important to you. He has analyzed some sample oranges from the grove in the background and found that they have the optimal amount of sugar, of acid, and are of the proper texture. (Testing for vitamin C comes later.) Homer Jackson knows that these oranges are of a quality to meet the exacting regulations required by the Florida Citrus Commission.

These standards for quality in citrus products are the highest in the world. This is important to you and your patients because juice made from the best oranges will be nutritionally best for your patients. It will contain abundant amounts of vitamin C and rich, natural fruit sugars.

It's good nutrition to encourage people to drink orange juice. It makes good sense to persuade them to drink orange juice that you *know* tastes good, has the right sugar-acid ratio, and is packed full of nutritionally important vitamin C.

©Florida Citrus Commission, Lakeland, Florida

# When it's more like "grippe" or



# "flu" than a simple cold, but an antibiotic is not indicated... prescribe NEW WIN-CODIN* Tablets

New Win-Codin tablets provide greater symptomatic relief from influenza, colds and sinusitis than do simple analgesic-antihistamine combinations. New Win-Codin tablets contain a full complement of the most effective agents available to relieve general discomfort, bring down fever and lessen congestive symptoms.

Each tablet contains:

*Codeine phosphate 15 mg.*—to relieve local and generalized pain and control dry cough

*Neo-Synephrine® 10 mg.*—to shrink nasal membranes and open sinus ostia

*Acetylsalicyclic acid 300 mg. (5 grains)*—to reduce fever and relieve aching

*Chlorpheniramine maleate 2 mg.*—an antihistamine to shrink engorged membranes and lessen rhinorrhea

*Ascorbic acid (vitamin C) 50 mg.*—to increase resistance to infections†

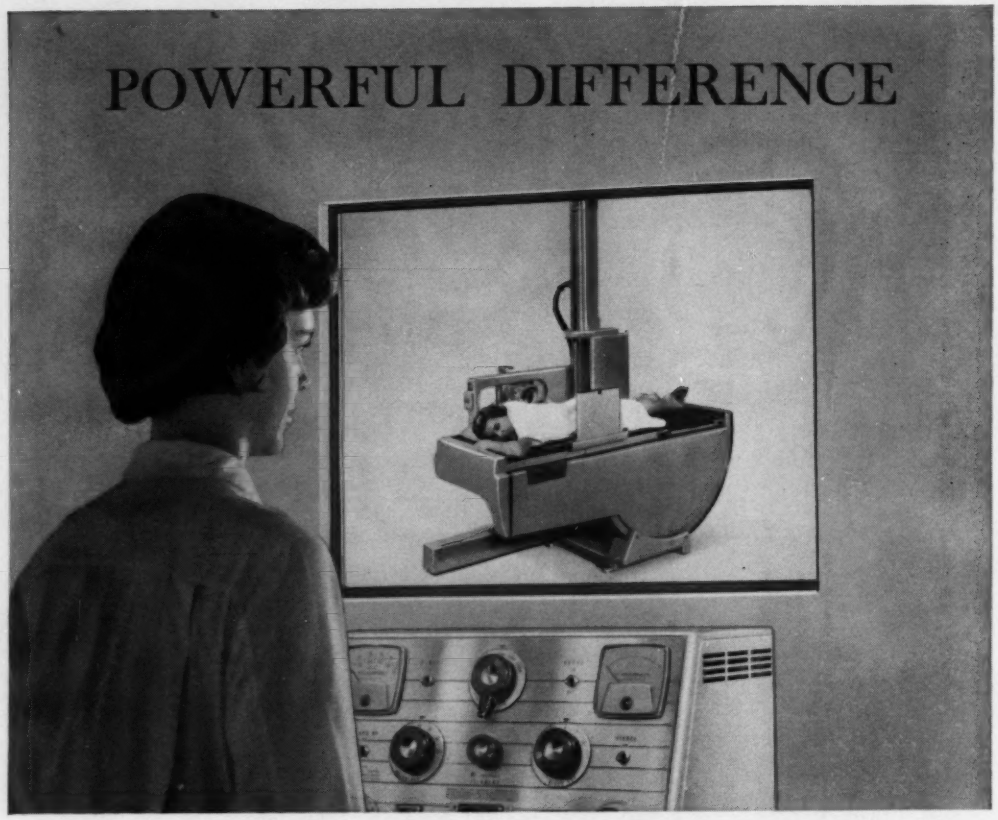
New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

*Average dose:* Adults, 1 or 2 tablets three times daily; children 6 to 12 years, from ½ to 1 tablet three times daily.

Available in bottles of 100 (Class B narcotic).

*Trademark †For persons with vitamin C deficiency
Neo-Synephrine (brand of phenylephrine), trademark reg. U. S. Pat. Off.

Winthrop LABORATORIES
New York 18, N. Y.




# ...motion-stopping radiographic speed is built into every Patrician "200"

With the G-E Patrician "200" diagnostic x-ray package, you can enjoy savings and still not sacrifice needed *power*. This is important. For, only ample x-ray output will assure you exposure speed sufficient to overcome common motion-blurring problems. The Patrician combination provides this *and more* in every detail for radiography and fluoroscopy. For example: full-size 81" tilting table . . . independent tube-stand . . . counterbalanced (not counterpoised) fluoroscopic screen or spot-film device . . . fine focus x-ray tube . . . fluoroscopic shutter-limiting device to confine radiation to screen area . . . automatic x-ray tube overload protection.

**Ask about renting:** Through the G-E Maxiservice® plan, you can have this complete Patrician "200," plus maintenance, parts, tubes, insurance, and paid-up local taxes — all wrapped-up by a modest monthly fee. Details available from your G-E x-ray representative listed below.

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**AN AMES CLINIQUICK®**

CLINICAL BRIEFS FOR MODERN PRACTICE

## Quality of diabetic control & Quantitation of urine-sugar

In the diagnosis of diabetes, the urine-sugar test may be little more than a screening adjuvant. But in the everyday management of diabetes, the urine-sugar test is the most practical guide we have.[1] Routine testing, however, should not only detect, but also determine the **quantity** of urine-sugar. Quantitative testing is essential for satisfactory adjustment of diet, exercise and medication. Furthermore, day-to-day control of diabetes is in the patient's hands. Quality of control is thus best assured by the urine-sugar test which permits the most accurate quantitation practicable **by the patient.**



CLINITEST® permits a high degree of practical accuracy and is very convenient.[3] Its clinically standardized sensitivity avoids trace reactions, and a standardized color chart minimizes error or indecision in reading results. CLINITEST distinguishes clearly the critical ¼%, ½%, ¾%, 1% and 2% urine-sugars. It is the only simple test that can show if the urine-sugar is over 2%.[3] Your nurse or technician will appreciate these advantages; your patient on oral hypoglycemic therapy will find them helpful. Furthermore, CLINITEST may be a vital adjunct in the management of the diabetic child or the adult with severe diabetes.

(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., **et al.**: Diabetes 7:398, 1958.

**FOR PRACTICAL ACCURACY OF URINE-SUGAR QUANTITATION**

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BRAND Reagent Tablets

**Standardized** urine-sugar test...with **GRAPHIC ANALYSIS RECORD**

A line connecting successive urine-sugar readings reveals at a glance how well diabetics are cooperating. Each CLINITEST Set and tablet refill contains this physician-patient aid. 01561

AMES COMPANY, INC. Elkhart, Indiana

Now...two new products to supply the iron infants[2] and children[1,3] need at the ages they need it

# TRI-VI-SOL®
## VITAMIN DROPS WITH IRON

# DECA-VI-SOL®
## CHEWABLE VITAMINS WITH IRON

These two new formulations—one for infants, one for older children—are distinctive additions to the present line of Vi-Sol® vitamins, thereby providing the choice of Tri-Vi-Sol drops with and without iron and Deca-Vi-Sol chewable vitamins with and without iron. Both new products taste good. The packaging carefully limits elemental iron to a total of 500 mg. per bottle. Nevertheless, the bottles should be kept out of the reach of children.

Tri-Vi-Sol vitamin drops with iron. Each 0.6 cc. daily dose supplies 10 mg. elemental iron plus safe, rational amounts of vitamins C, D and A. Supplied in bottles of 30 cc.

Deca-Vi-Sol chewable vitamins with iron. Each chewable tablet supplies 10 mg. elemental iron and safe, rational amounts of C, D and A plus seven significant B vitamins. Supplied in bottles of 50 chewable tablets.

Bibliography: (1) Jacobs, I.: GP *21*:93 (Jan.) 1960. (2) Shulman, I.: J.A.M.A. *175*:118-123 (Jan 14) 1961. (3) Moore, C. V., in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, ed. 2, Philadelphia, Lea & Febiger, 1960, p. 243.

## 10 mg. of prophylactic iron... logically combined for your convenience with two of the most widely used and accepted pediatric vitamin products

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